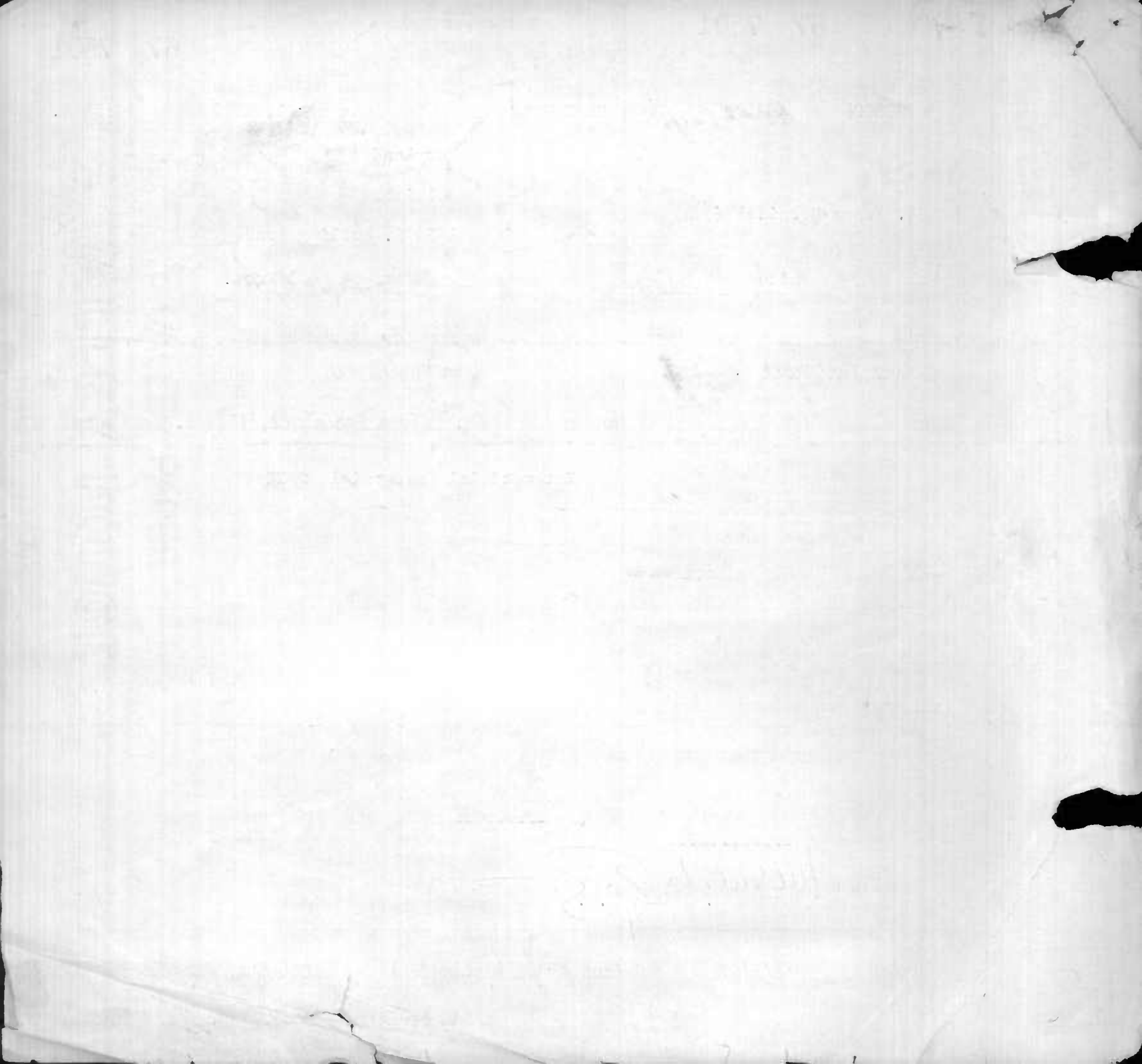


BIRTH NO. 67-10246		7501		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 7501	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) MINICK <i>Kyles</i> FARINHOLT					2. DATE AND HOUR PRONOUNCED DEAD August 1, 1967 10:50 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1524 S. Rolling Road				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2 Months 11 Days	9. AGE (In years last birthday) 2 Months 11 Days	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Farinholt					14. MOTHER'S MAIDEN NAME Myra Rubenstein				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Oliver Farinholt, 1524 S. Rolling Road				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS SDII ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
INTERVAL BETWEEN ONSET AND DEATH									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/1/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/3/67		23C. NAME of CEMETERY or CREMATORY Chizuk Amuno (Arlington)		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
24A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR Sob. Levinson & Bros. Inc., 6010 Reist., Rd.					



FUNERAL DIRECTOR: IMPORTANT

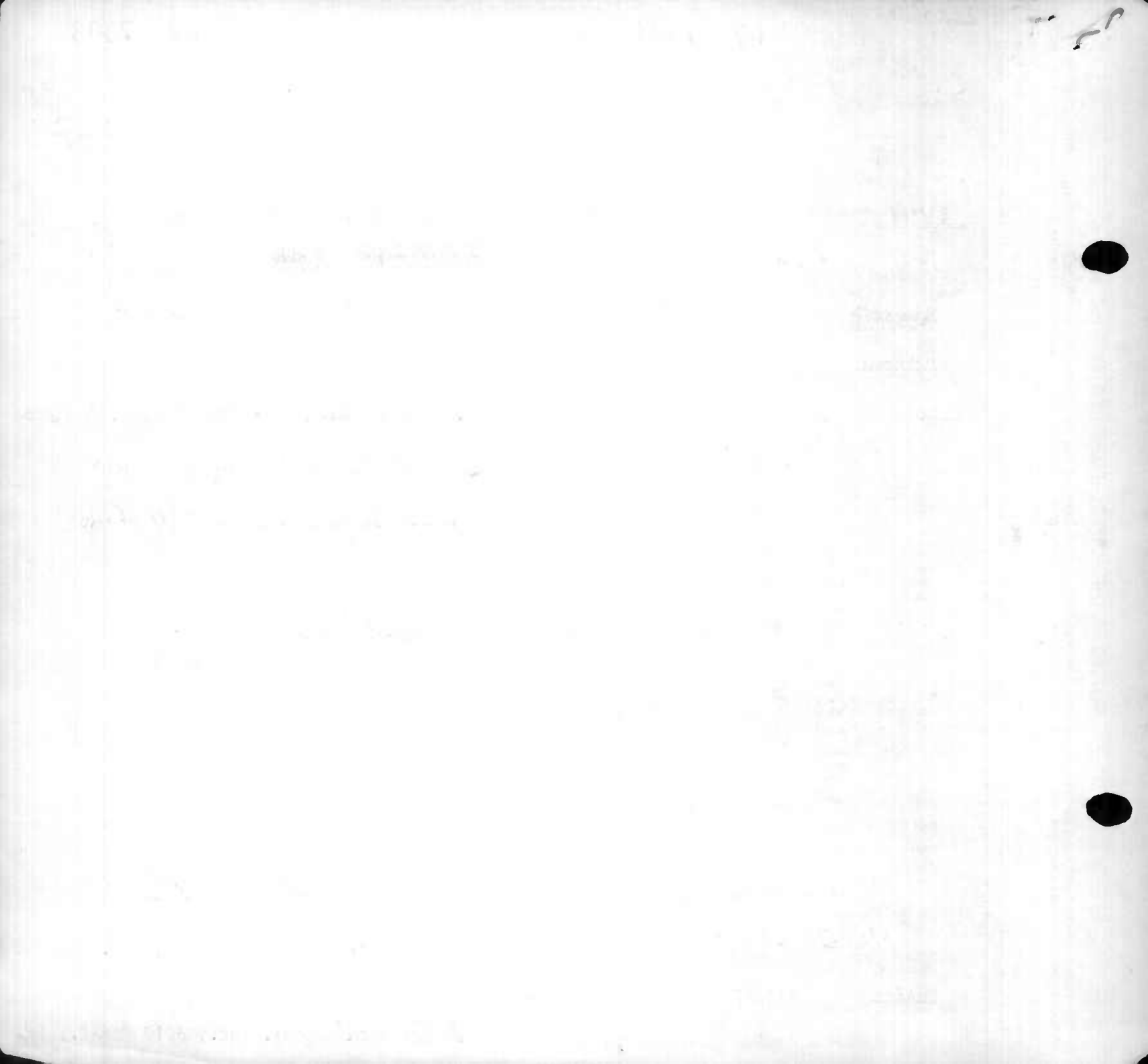
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7502		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 67 7502	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROSE JACOBSON			2. DATE AND HOUR OF DEATH 8/2/67 2:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin SQUARE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7526 W FAIRMOUNT Avenue		
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9/17/97	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME PHILIP MARGOLIES			14. MOTHER'S MAIDEN NAME JENNIE WOLF		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Medical chart ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 334X I Cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH years			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. septicemia day ? carcinoma		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/1/67 to 8/2/67, that (I) (we) last saw the deceased alive on 8/2/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymundo S. Magno M.D.				23B. DATE SIGNED 8/2/67	
23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNO M.D.				23D. ADDRESS Franklin Square Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/3/67		24C. NAME OF CEMETERY or CREMATORY ADATH JESHURUN (SODOVA)	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			
25B. NAME OF REGISTRAR Robert E. Hatcher, M.D.		25C. FUNERAL DIRECTOR SOP LEVINSON & BROS. INC., 6010 REIST., RD.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

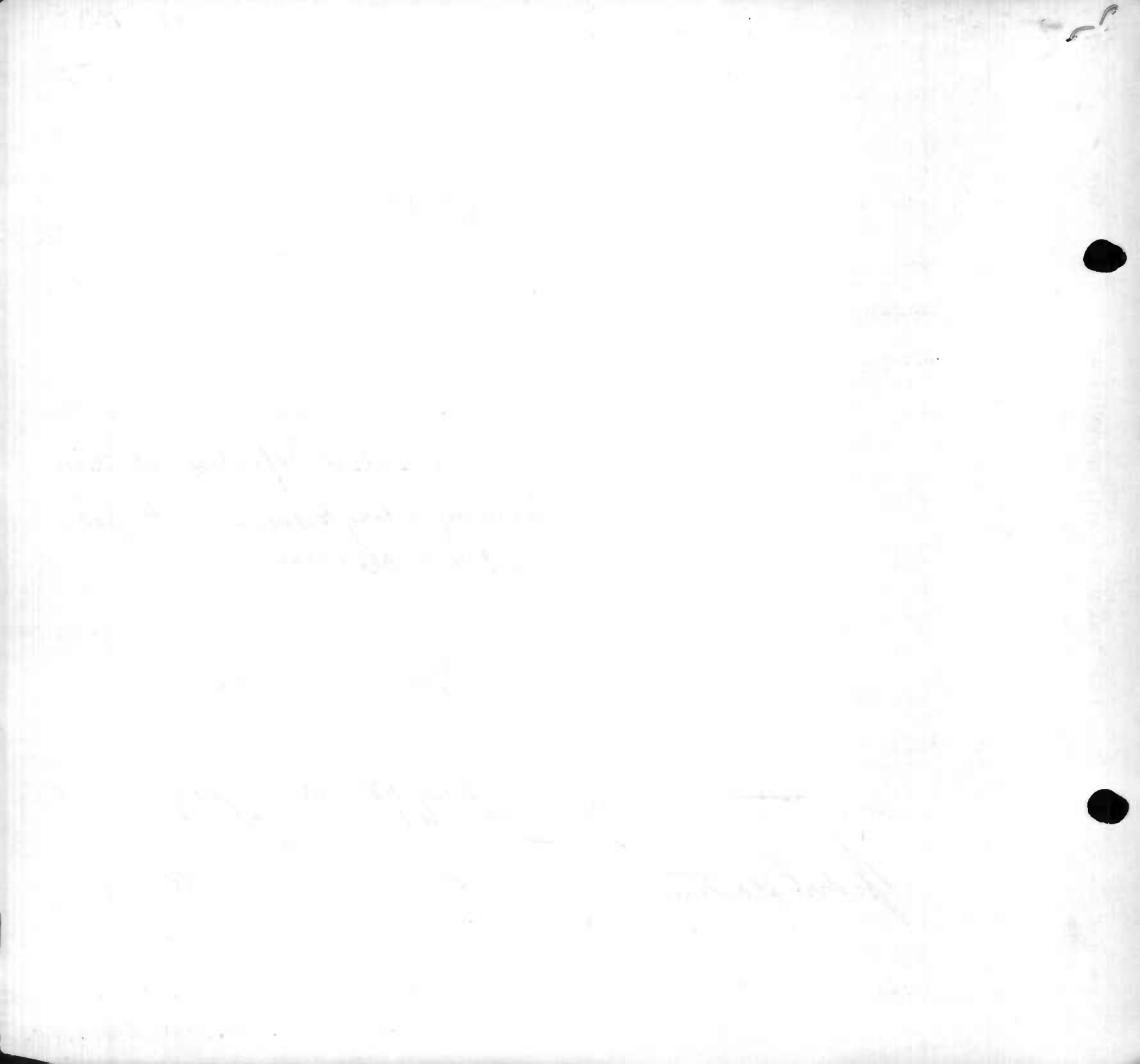
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7503	
BIRTH NO. M.E. CASE NO.		67 7503		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FISH - YETTA			2. DATE AND HOUR OF DEATH 8-2-67 11:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTO., INC.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MA. B. COUNTY 27-20		
5. SEX F			6. RACE W		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED			8. DATE OF BIRTH XXXXXXXXXX		
9. AGE (In years lost birthday) 80			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		
11. BIRTHPLACE (State or foreign country) RUSSIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. UNKNOWN		
17. INFORMANT Mr. Morris Vaker, Belvedere Towers, Apt 423			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. heatus berina + Cholelithiasis			CAUSE OF DEATH (A) Pulmonary Edema for 4 days DUE TO (B) Myocardial Infarction 4 days DUE TO (C) _____		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED Wife At Work <input type="checkbox"/> Not Wife At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mare Lowen			23B. DATE SIGNED 8/2 3:30 Am		
23C. PHYSICIAN'S NAME (Type) MARE LOWEN			23D. ADDRESS Sinai Hospital of Baltimore, Inc.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8/3/67		
24C. NAME OF CEMETERY or CREMATORY Shaarei Tfiloh			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			25B. NAME OF REGISTRAR R. E. Fink		
25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7504</u>	
BIRTH NO. <u>5-1350</u>		67 7504		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MORRIS STEIN</u>		2. DATE AND HOUR OF DEATH <u>July 31, 1967</u> <u>11:11 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-41</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>4003 Groveland Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>77</u>	9. AGE (In years lost birthday) <u>77</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mrs. Sadie Stein, 4003 Groveland Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		CAUSE OF DEATH (A) DUE TO <u>Coronary Artery Disease</u> (B) DUE TO <u>Arteriosclerosis</u> (C) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>4 yrs.</u>	
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>July 28</u> 19 <u>66</u> to <u>July 31</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>June 28</u> , 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Herbert Colostone</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Aug. 1, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>HERBERT COLOSTONE</u>		23D. ADDRESS <u>3643 GLENGYLE AVE.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/3/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Hebrew</u>	
24D. LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SQL Levinson & Bros. Inc., 6010 Reist., Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7505		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7505	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) PAULINE BUFF		
2. DATE AND HOUR OF DEATH 8-2-67			3. PLACE OF DEATH IN BALTIMORE, MARYLAND 48 MARYLAND GENERAL Hosp		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
6. STREET ADDRESS (If rural, give location) 1704 E. 33RD ST			7. SEX F		
8. RACE W			9. MARIED, NEVER MARIED WIDOWED, DIVORCED (specify) Widowed		
10. DATE OF BIRTH 1900			11. AGE (In years last birthday) 66		
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Numerical Registor			13. KIND OF BUSINESS OR INDUSTRY Social Security		
14. BIRTHPLACE (State or foreign country) Baltimore Maryland			15. CITIZEN OF WHAT COUNTRY? U.S.A.		
16. FATHER'S NAME Charles E. Diver			17. MOTHER'S MAIDEN NAME Margaret V. Kearney		
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			19. SOCIAL SECURITY NO. 10-11-1961		
20. INFORMANT Mrs Anna Tolle			21. ADDRESS 1 Sipple Avenue 21236		
22. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Mitral Stenosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Rheumatic heart disease			23. INTERVAL BETWEEN ONSET AND DEATH		
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
25. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from 8-2 19 67 to 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy K. Gray MD				23B. DATE SIGNED 8-2-67	
23C. PHYSICIAN'S NAME (Type) TIMOTHY KENNEY GRAY				23D. ADDRESS MARYLAND GENERAL Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-1967		24C. NAME OF CEMETERY or CREMATORY Gardens Of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			
25B. NAME OF REGISTRAR John B. Taylor		25C. FUNERAL DIRECTOR John B. Taylor			
25D. ADDRESS 74 N. Adams Road					

Handwritten notes and diagrams on lined paper, including:

- Top right: "MH" and "8-7-67"
- Top left: "V.S. 153"
- Left side: "1000 ft. deep" and "1000 ft. deep"
- Center: "1000 ft. deep" and "1000 ft. deep"
- Right side: "1000 ft. deep" and "1000 ft. deep"
- Bottom: "1000 ft. deep" and "1000 ft. deep"

The page contains several faint, handwritten notes and diagrams, including a large "X" and various numbers and letters.

67 7506

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7506

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HORTENSE T. LAWS

2. DATE AND HOUR PRONOUNCED DEAD

August 2, 1967 6:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL D.O.A.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1224 N. Bentalou St.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

May 3-1909

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

David Laws

14. MOTHER'S MAIDEN NAME

Ida Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Hortense Laws 1224 N. Bentalou St.

18. E 902.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Subdural Hematoma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1224 N. Bentalou Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

? ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell off of wheel chair

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 2, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/6/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

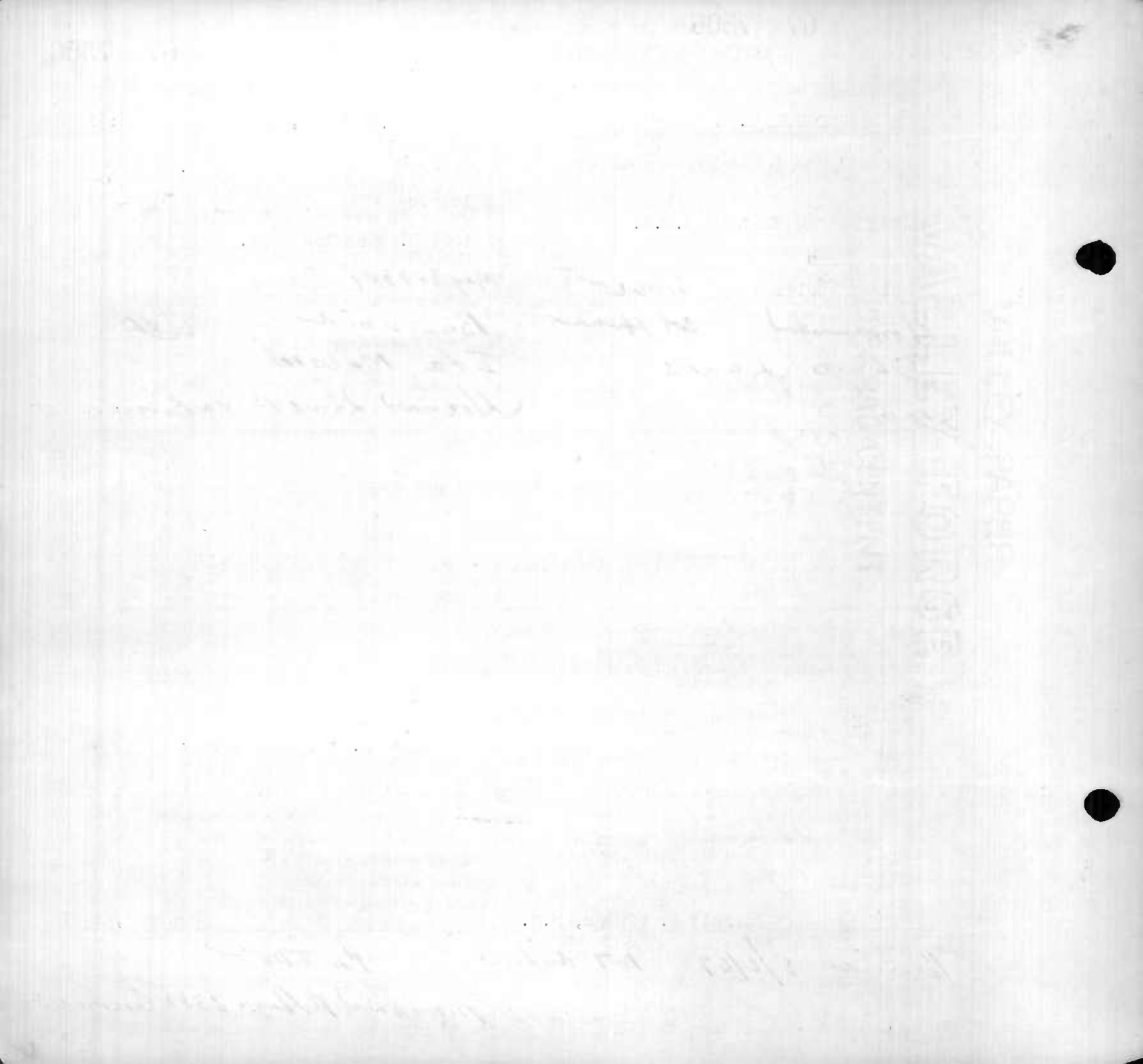
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

James P. May 638 N. Bentalou St

ADDRESS



B-400

67 7507

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7507

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
GEORGE

E.

BELL

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1967

2:35 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2921 Ellicott Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2921 Ellicott Drive

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG. 15, 1912

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TRUCK LOADER

10B. KIND OF BUSINESS OR INDUSTRY

SEALTEST DAIRY LUNENBURG CO. VA

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM BELL

14. MOTHER'S MAIDEN NAME

MARTHA JANE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

229 260188

17. INFORMANT

ADDRESS

The Bel 2921 Ellicott Dr.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Subarachnoid Hemorrhage
DUE TO ruptured berry aneurysm

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREWerner U. Spitz, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/4/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

Aug 6, 1967

23C. NAME of CEMETERY or CREMATORY

Kenbridge Cemetery

23D. LOCATION

(City, town, or county) (State)
Kenbridge Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

24B. NAME OF REGISTRAR

Robert E. Jones

24C. FUNERAL DIRECTOR

Marshall P. Hayes

ADDRESS

638 N. Belmor St.
Bar S. P. Jones Funeral Hs. Kenbridge Va.

THE JAMES EARL RAY
MURDER CASE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARTHA

COTTMAN

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967

5:56 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1915 W. Fairmount Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1915 W. Fairmount Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

DEC 5, 1909

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Home Make

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Petersburg Va

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JACOB WOODLEY

14. MOTHER'S MAIDEN NAME

CORA JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

GEORGIA W. FISHER

ADDRESS

1915 FAIRMOUNT AVE.

18.

H22.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

8/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

8.5-67

23C. NAME of CEMETERY or CREMATORY

Little Mount

23D. LOCATION

Petersburg Va

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Blair F. Home

ADDRESS

638 N. Gilman St

WILLIAM H. HOLT

WILLIAM H. HOLT

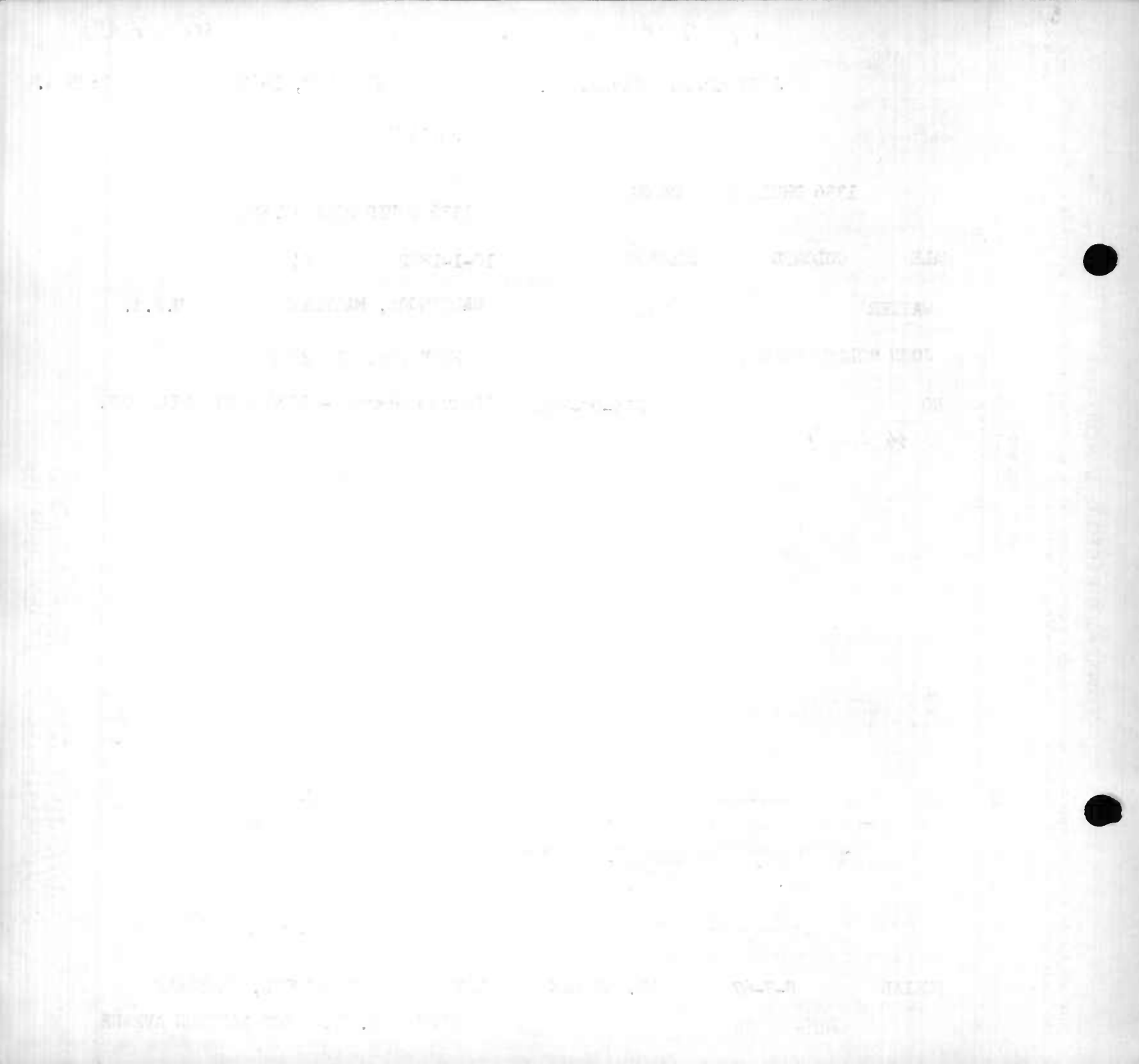
WILLIAM H. HOLT

WILLIAM H. HOLT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

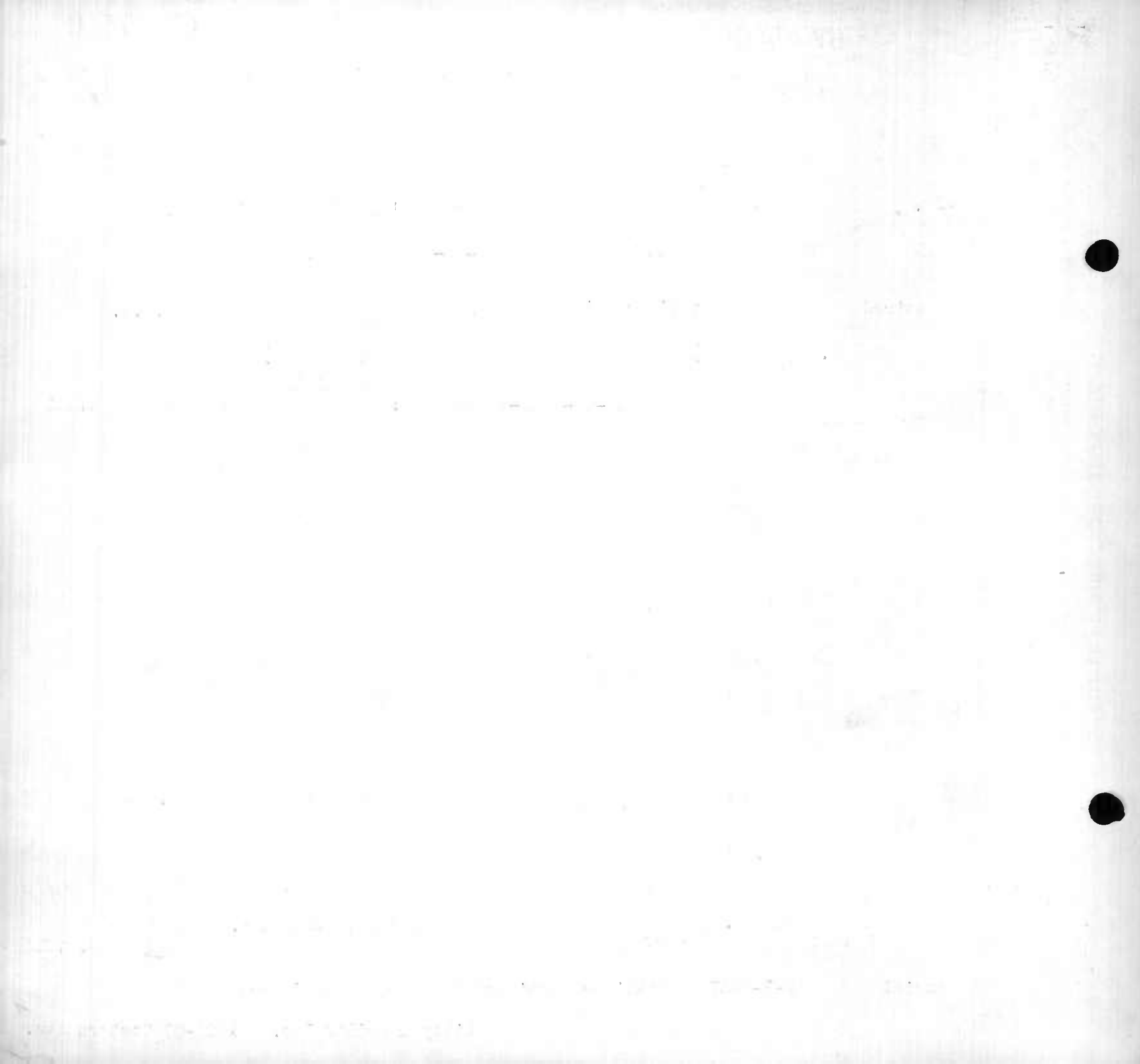
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7509	
BIRTH NO. 67 7509		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN EDWARD WEAVER, SR.		2. DATE AND HOUR OF DEATH AUGUST 3, 1967 2:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00 1336 DRUID HILL AVENUE		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 1336 DRUID HILL AVENUE		17-02	
5. SEX MALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 10-1-1882	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10B. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN ROLAND WEAVER		14. MOTHER'S MAIDEN NAME MARY VIRGINIA BRYAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-07-8984A		17. INFORMANT ADDRESS Theresa Weaver - 1336 DRUID HILL AVE.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterograde Cardiac-vascular Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-1 19 67 to 8-3 19 67 , that (I) (we) last saw the deceased alive on 8-3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Philip D. Flynn		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-4-67	
23C. PHYSICIAN'S NAME (Type) Philip D. Flynn		23D. ADDRESS 11 E Chase St, Baltimore, Md. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-7-67		24C. NAME of CEMETERY or CREMATORY MT. AUBURN CEMETERY	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. STATE (State) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW 802 MADISON AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7510	
BIRTH NO. 67 7510		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Albert T. Snee (ALBERT J. SNEE)		Aug. 3, 1967 9:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-05	
5. SEX MALE		D. STREET ADDRESS (If rural, give location) 6606 O'DONNELL STREET 21224	
6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED (specify)	B. DATE OF BIRTH 5-29-1893	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK J. (DECEASED)		14. MOTHER'S MAIDEN NAME AGNES (DECEASED)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-10-5924-A	
		17. INFORMANT BCN 4940 EASTERN AVENUE RECORDS: BALTIMORE, MARYLAND 21224	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of lung (B) 2 yrs (C) INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from May 24 1967 to Aug. 3 1967 , that (1) (we) lost saw the deceased alive on 8-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ross T. Krueger		23B. DATE SIGNED Aug. 3, 1967	
23C. PHYSICIAN'S NAME (Type) ROSS T. KRUEGER		23D. ADDRESS Balt. 4940 Eastern Ave Hosp BALTO. MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-7-1967	24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Stankewitz	
		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.	
		ADDRESS 1901-07 Eastern Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 7511**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**VOLDERMAR POLD**

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1967 | **5:35 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

238 So. Broadway

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Single**

8. DATE OF BIRTH

9. AGE (In years
last birthday)**57**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Seaman**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Estonia12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.**094-14-1951**

17. INFORMANT

ADDRESS

Seafarers International Union **Baltimore St.****1216 E.**

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Fatty liver**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)
DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**YES**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

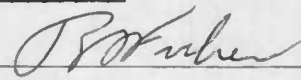
21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)**Russell S. Fisher, M.D.****August 4, 1967**23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8-7-1967

23C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

Baltimore, County, Maryland

(State)

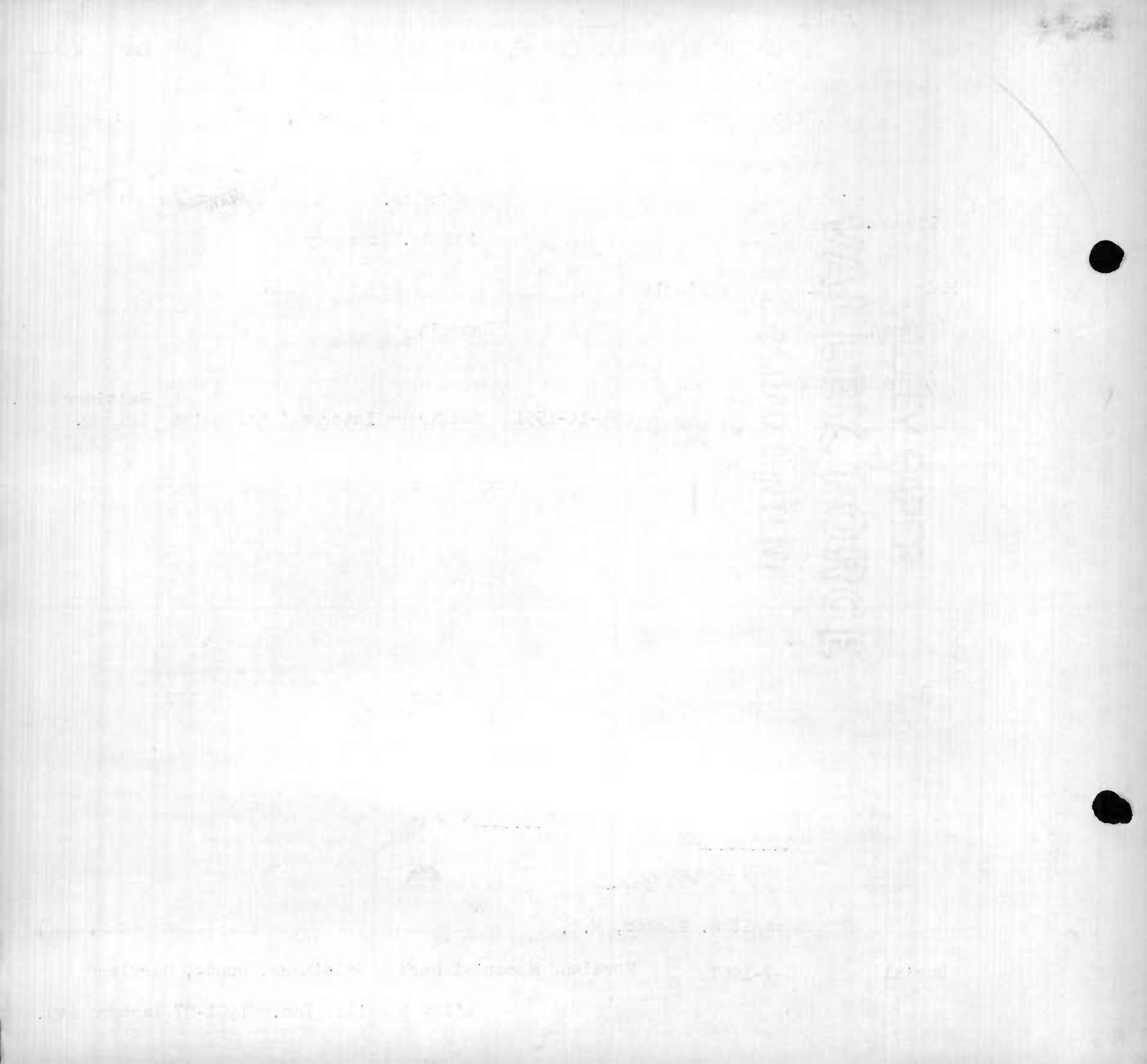
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

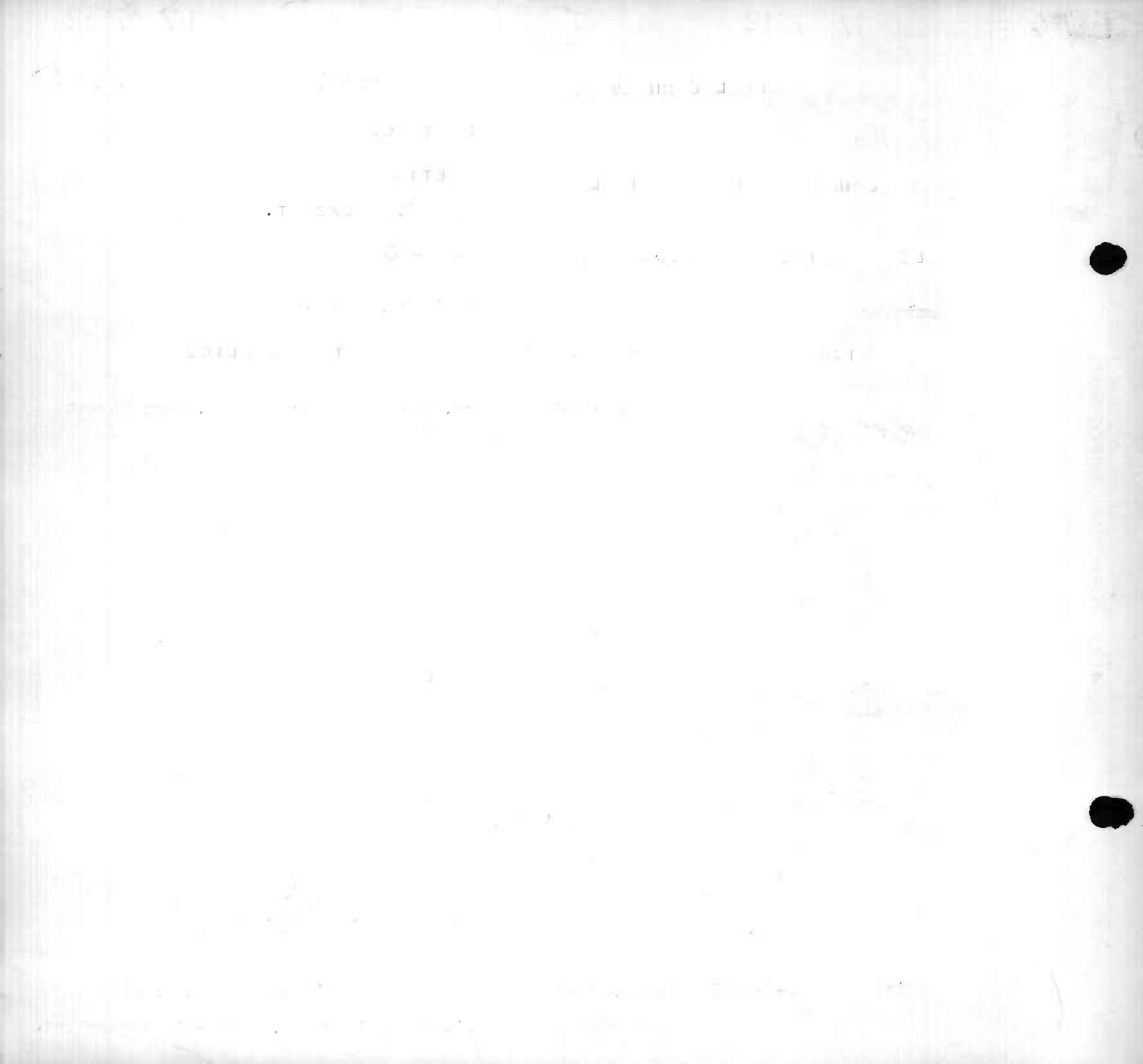
AUG 7 1967**Robert E. Fisher****Lilly & Zeiler Inc. 1901-07 Eastern Ave.**



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7512				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7512	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
SAMUEL JOHN EVERD				2. DATE AND HOUR OF DEATH 8-3-67 3:45 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				A. STATE B. COUNTY MARYLAND			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 233 S. WOLFE ST. 21231			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-29-26	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME NICHOLAS Everd			14. MOTHER'S MAIDEN NAME MARGARET ZEBERLINE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-12-7055		17. INFORMANT Mrs. Jeanette Everd 620 S. Port Street		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 019.21 CAUSE OF DEATH Secondary Addison's Disease Military Tuberculosis (A) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 18 months at least				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) None DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			None (C)				
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/29 19 67 to 8/3 19 67, that (we) lost saw the deceased alive on 8/3/67 at 3:45 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R. Stone				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/3/67	
23C. PHYSICIAN'S NAME (Type) John R. Stone				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-1967		24C. NAME OF CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zailer Inc. 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 7513					Registered No. 67 7513				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <i>ROSE CAMPBELL, Rose L. Hays</i>					2. DATE AND HOUR OF DEATH 8-4-67 7 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>LUTHERAN HOSPITAL OF MARYLAND</i>					A. STATE B. COUNTY <i>MARYLAND 21229</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>				
					D. STREET ADDRESS (If rural, give location) <i>627 EDGEWOOD St.</i>				
5. SEX <i>FEMALE</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i> <i>Separated</i>	8. DATE OF BIRTH <i>7-26-21</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNEMPLOYED</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>KY.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Rosa Lee Bee</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Andrew M. Hays</i> <i>4003 St. James Ave</i> <i>Louisville Ky</i>		ADDRESS <i>Same.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>578X I</i>			CAUSE OF DEATH (A) DUE TO <i>GASTRO INTESTINAL HAEMORRHAGE</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO						
			(C) DUE TO						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (t) (this hospital) attended the deceased from <i>8-1-1967</i> to <i>8-4-1967</i> , that (l) (we) last saw the deceased alive on <i>8-4-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes, stated above, (l) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>S. A. 12</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-4-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>S. A. 12</i>					23D. ADDRESS M.D. <i>LUTHERAN HOSPITAL OF MD., BALTIMORE, MD 21216</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-9-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>William L. McQuinn</i> <i>2302 W. North Ave</i> <i>Balt 16 Md</i>			
						ADDRESS			

67 7514

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7514

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY

STEEG

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967

12:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

112 N. Lakewood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/2/1896

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co. Baltimore, Maryland

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Steeg

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Fredericka Steeg 112 N. Lakewood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/9/1967

23C. NAME of CEMETERY or CREMATORY

Mount Carmel Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

John A. Moran Inc. 3000 E. Baltimore St.

ADDRESS

215 50

1121

2-2

25/10/1960

10/11/1960

11/11/1960

12/11/1960

13/11/1960

14/11/1960

15/11/1960

16/11/1960

17/11/1960

18/11/1960

19/11/1960

20/11/1960

21/11/1960

22/11/1960

23/11/1960

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11/11/1960

12/11/1960

13/11/1960

14/11/1960

15/11/1960

16/11/1960

17/11/1960

18/11/1960

19/11/1960

20/11/1960

21/11/1960

22/11/1960

23/11/1960

24/11/1960

25/11/1960

26/11/1960

27/11/1960

28/11/1960

29/11/1960

30/11/1960

1/12/1960

2/12/1960

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RACHEL BABER

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967

10:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2611 Garrison Blvd. Apt C1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2611 Garrison Blvd. Apt C1

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Female

Colored

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M.E.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

196-20-4578

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

August 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-10-67

23C. NAME of CEMETERY or CREMATORY

Crown View Park

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

G. W. Wright

ADDRESS

2708 Edmonson Ave.

WALLLEY PAPER

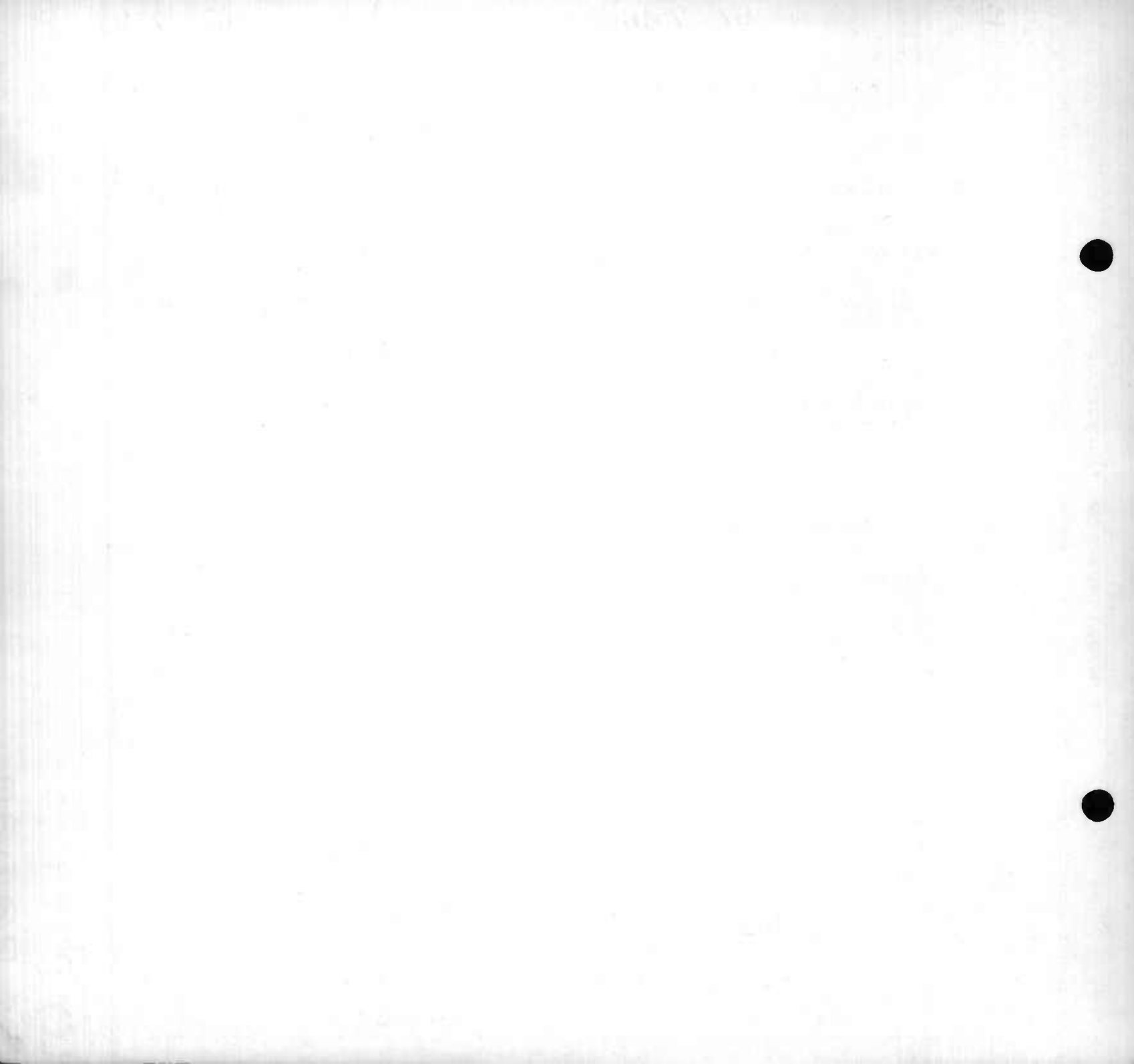
WALLLEY PAPER

WALLLEY PAPER

WALLLEY PAPER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7516		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7516	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				A. CATHERINE E. DANIELS			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION				8 - 2 - 67 4: 45 A.M.			
(If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
LUTHERAN HOSPITAL OF MARYLAND				A. STATE MARYLAND, 625 N. BRICE ST. BALTO 21217			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 16-04			
				D. STREET ADDRESS (If rural, give location)			
				625 N. BRICE ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
FEMALE	C	WIDOW	12-25-80	86			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NONE Housewife				FLORIDA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alfred Acosta				Isabel Clayton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
UNKNOWN		-		CHART		629 N. BRICE ST. BALTO.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) RECTAL HAEMORRHAGE				7 days	
ANTECEDENT CAUSES		(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
-		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-			
22. I certify that (I) (this hospital) attended the deceased from 7-26 1967 to 8-2 1967, that (I) (we) last saw the deceased alive on 4 am 8-2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
S. Aziz						8-2-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D. LUTHERAN HOSPITAL OF MARYLAND, BALTO, MD 21216			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/5/67		Orchard Memorial Park		Orchard (Baltimore) Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 7 1967		Robert E. Taylor, MA		Joseph L. Lewis		2222 N. North Ave, Baltimore, Md.	



1
17-100

67 7517 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7517

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VERNON O. NEWBY

2. DATE AND HOUR PRONOUNCED DEAD

August 2, 1967 5:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 725 George Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

725 George Street Apt. 11-H

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 28, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. II Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Burr, Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Oscar Newby

14. MOTHER'S MAIDEN NAME

Elizabeth Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

231-15-0865

17. INFORMANT

ADDRESS

Mr. Howard Newby 2421 Westwood Ave.

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/3/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

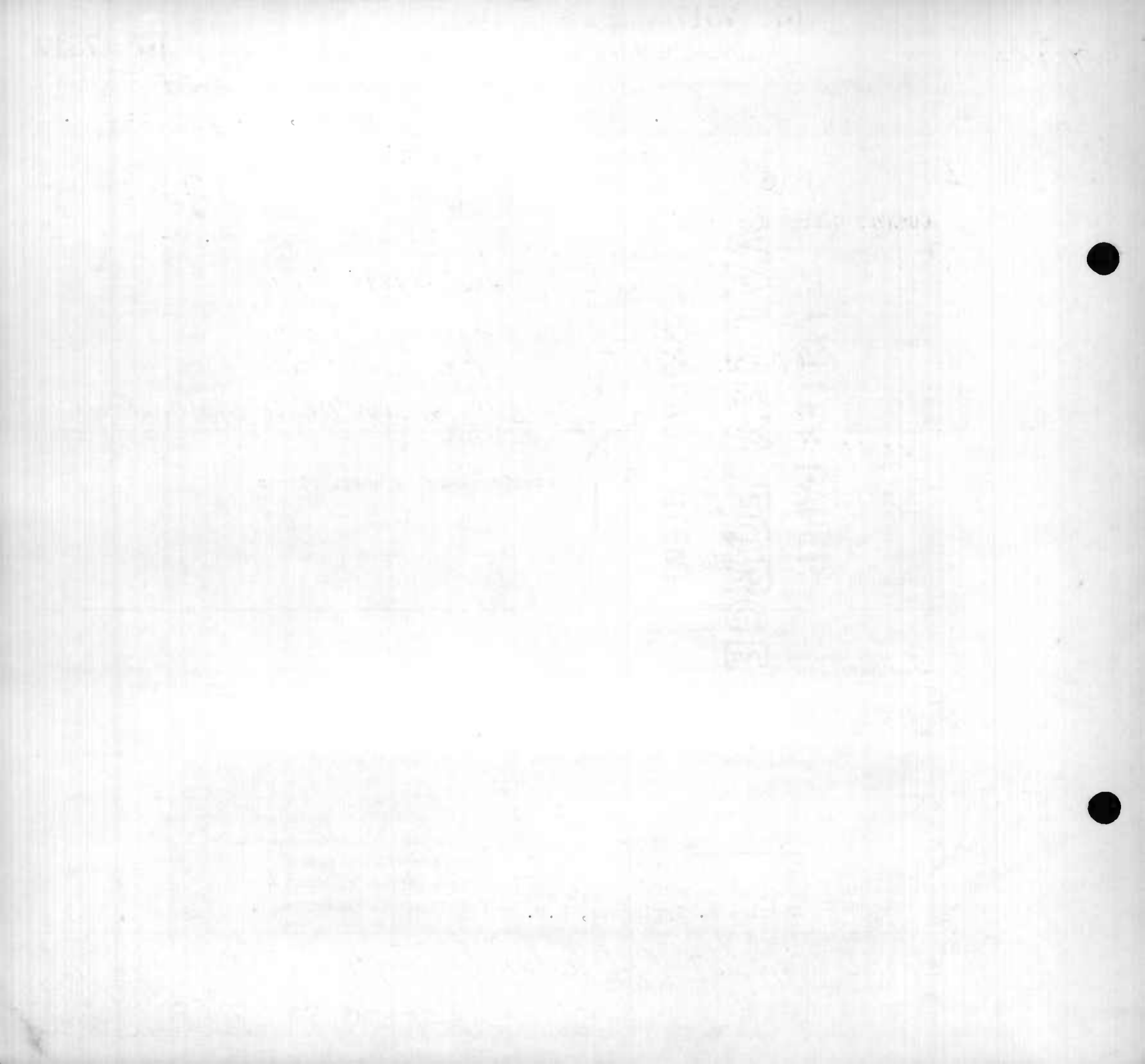
(City, town, or county) (State)
Westport (Baltimore) Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Joseph L. Russ 2421 W. North Ave.
Baltimore, Md.



1
W-300

67 7518

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7518

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BARBARA WHITE

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1967 8:35 p.m.

3. PLACE IN BALTIMORE, MAR. AND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1922 Ridgehill Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Feb. 13, 1955

9. AGE (in years
last birthday)

12

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginis

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles White

14. MOTHER'S MAIDEN NAME

Rosetta Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Richardson 616 Dennison Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Payson Street and Ridgehill

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 3 67 7:20 p

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject hit while riding bike

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

August 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 9, 1967

23C. NAME of CEMETERY or CREMATORY

Franklin Cemetery

23D. LOCATION

Franklin

(City, town, or county)

(State)

Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

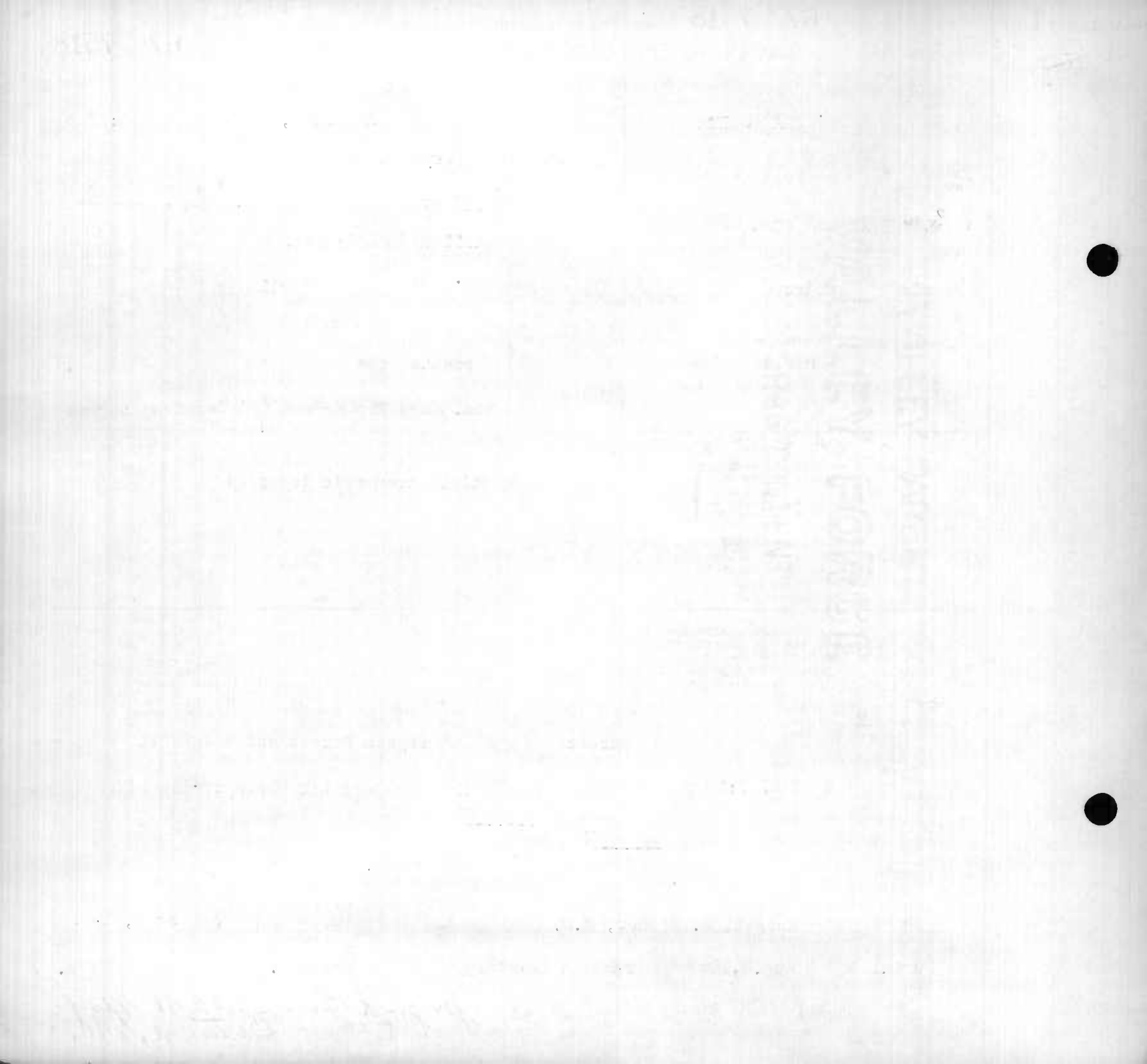
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

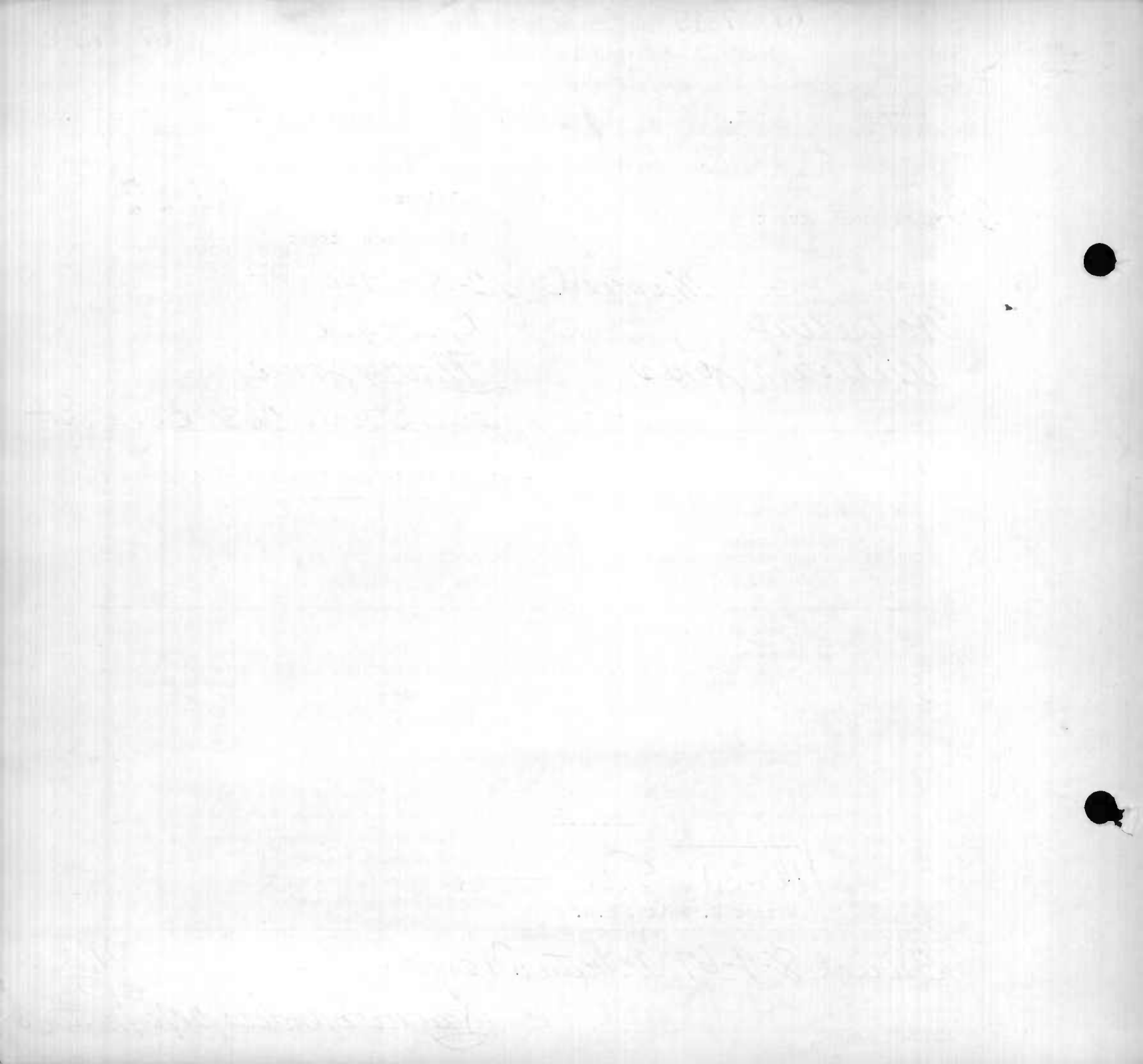
Joseph L. Rues 2222 W. North
Baltimore, Md.

ADDRESS



S-314

BIRTH NO.		67 7519		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 7519			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) LETTIE I. STOVALL				2. DATE AND HOUR PRONOUNCED DEAD August 5, 1967 10:35 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2630 Boone Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2630 Boone Street				9-04			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-18-1900	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Jones			14. MOTHER'S MAIDEN NAME Mary Jones			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. —		
17. INFORMANT James Stovall			ADDRESS 2630 Boone St			18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			23A. BURIAL CREMATION, REMOVAL (Specify) Burial			23B. DATE 8-9-67			23C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		
24A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			24B. NAME OF REGISTRAR Robert E. Finken			24C. FUNERAL DIRECTOR Rayner Sanders			24D. LOCATION (City, town, or county) (State) 2176 Preston St Md		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7520

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROLAND JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

July 29, 1967

1:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1725 Guilford Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Sep

8. DATE OF BIRTH

Apr 5-1944

9. AGE (in years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Irrvin H. Johnson Sr.

14. MOTHER'S MAIDEN NAME

Fuzzie Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-42-2095

17. INFORMANT

Fuzzie Moore 1725 Guilford Ave

ADDRESS

18.

E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple gunshot wounds
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

50-75 ft. East of Callow St. Even Side

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 29 67 1:00 a.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject was shot during argument

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 29, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-4-67

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Em A.A. Co

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 7 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Rayner Sanders 217 E. Preston St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7521		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7521	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Milton J. Williams, SR.		2. DATE AND HOUR OF DEATH THUR 8-3-1967 11:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 24-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230	
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 302 E. Fort AVE.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 9-29-1892	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Pressman		10B. KIND OF BUSINESS OR INDUSTRY NEWSPAPER		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George E. Williams		14. MOTHER'S MAIDEN NAME Ellen Eason	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-5683		17. INFORMANT Ellen C. Craig (Dth.)	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteinemia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovas. Disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Coronary Heart Failure		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8-1 19 67 to 8-3 19 67 , that (we) last saw the deceased alive on 8-3 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald M. Wood				23B. DATE SIGNED 8/4/67	
23C. PHYSICIAN'S NAME (Type) Donald M. Wood		23D. ADDRESS 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 5-67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem	
24D. LOCATION Glen Burnie Md		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR CURTIS E. EVANS	
25D. ADDRESS 1400		25E. (City, town, or county) Baltimore			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 7522		67 7522	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Louise Copeland				August 1, 1967 3:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE	
39		Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		Maryland	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore, 3-02	
				D. STREET ADDRESS (If rural, give location)	
				107 Albemarle Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	Widowed	10-12-1903	63 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Cook - (Domestic)			Virginia		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Rawles			Sarah Rawles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		212-32-30564		Mr. Thomas Copeland (Son) 2500 Druid Hill Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
155.1 I		CARCINOMA - GALL BLADDER (For Advanced)			
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		cholelithiasis, Hepatic Necrosis			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8/1/67	Gall Bladder Disease	Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 11, 1967 to August 1, 1967, that (I) (we) last saw the deceased alive on August 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Archie Robinson, Jr.				8-4-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		803 N. Fremont Avenue Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)	(State)
Burial	8-7-67	Mt. Auburn Cem.		Balto.	Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 7 1967		Robert E. Taylor		Morton & Dych F.H. 1701 LAURENS	

ADVANCED (FOR
BRIDGE) (FOR
CARRIAGE - CAR)

Cholesterol, Hepatic Vessels

2/1/67 San Antonio, Texas

Robert L. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7523		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7523	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) JAMES BRIDGES				2. DATE AND HOUR OF DEATH August 4, 1967 3:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2401 Brookfield Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 8/23/31	9. AGE (In years last birthday) 35 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Bridges				14. MOTHER'S MAIDEN NAME Maggie Bridges			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-30-2398		17. INFORMANT Mrs. Lillie Bridges		ADDRESS 2401 Brookfield	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 381.001 260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Nutritional Cirrhosis DUE TO (B) Alcoholic Cirrhosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 4, 1967 to August 4, 1967 , that (I) (we) last saw the deceased alive on August 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard H. Band M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 4, 1967	
23C. PHYSICIAN'S NAME (Type) Richard H. Band.				23D. ADDRESS Md. Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Q. E. S. Taylor		25C. FUNERAL DIRECTOR Morton's Dyett F.H.		ADDRESS 1701 Laurens	

JAMES BELORE

~~_____~~

2001 Rockledge Ave.
Baltimore

8/22/91 22 yrs

Baltimore Maryland

International Criminal

Justice Institute

1000 1st St. N.W.

Wash

August 10, 1991

Richard H. Bell

Richard H. Bell

Washington County Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

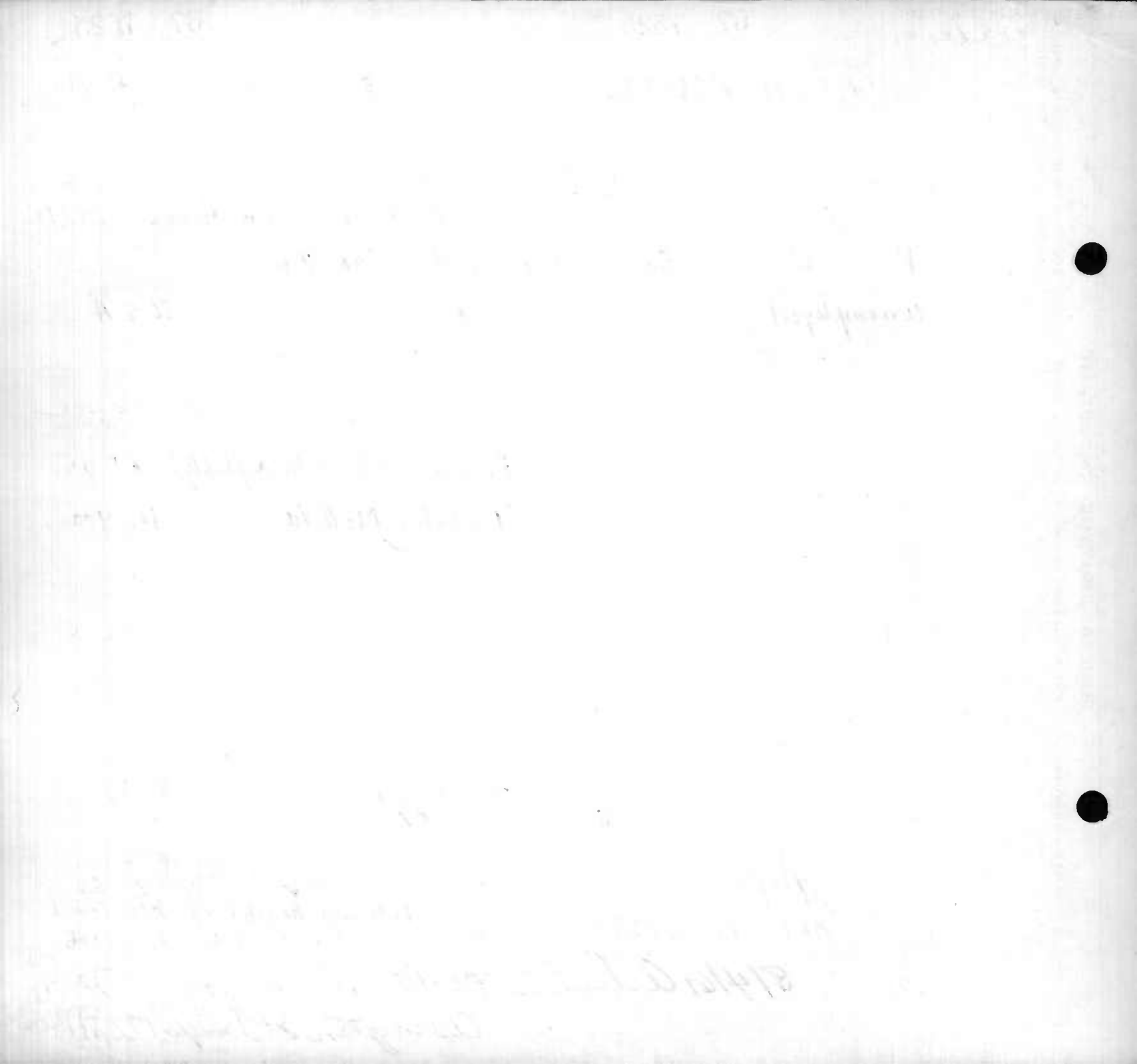
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7524	
BIRTH NO.		67 7524		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lewes, Mary E. (Lewis)		2. DATE AND HOUR OF DEATH 8-7-67 5 15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		D. STREET ADDRESS (If rural, give location) 2520 Glyndon Ave. 21217		E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 8-2-1921	9. AGE (In years, lost birthday) 46	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia, Richmond	
13. FATHER'S NAME Tymes, Henry		14. MOTHER'S MAIDEN NAME White, Rosa		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or duties of service) —		16. SOCIAL SECURITY NO. 231-20-2448		17. INFORMANT Mr. Nathanie Lewis	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 199.1		CAUSE OF DEATH (A) Terminal Ca, breast (B) Ca neck with metastases (C) —		INTERVAL BETWEEN ONSET AND DEATH 2520 Linden	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-4-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-4-67 to 8-7-67 , that (I) (we) last saw the deceased alive on 8-7-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Lewis		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/67	
23C. PHYSICIAN'S NAME (Type) Goodman, Louis (attending)		23D. ADDRESS Medical Arts Bldg. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-67		24C. NAME of CEMETERY or CREMATORY Da Ho. Nat'l Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.		ADDRESS 1701 Laurens	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7525		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7525	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SMITH ROSETTA		2. DATE AND HOUR OF DEATH 8-2-67 5 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-03	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland		D. STREET ADDRESS (If rural, give location) 1658 Warwick Avenue 21216			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sing. (N.M.)	8. DATE OF BIRTH 7-22-1946	9. AGE (In years lost birthday) 20 26 years	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Albert Smith		14. MOTHER'S MAIDEN NAME Helen Calston	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chas. Helen Smith Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I		CAUSE OF DEATH (A) DUE TO Euraemia (Diabetic Nephropathy) (B) DUE TO Diabetes Mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH - 8 1 year 14 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-29-67 19 to 8-2-67 19, that (I) (we) last saw the deceased alive on 8-2-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anjosh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-2-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton St. Baltimore - 21216.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/67		24C. NAME OF CEMETERY or CREMATORY Ashburton Menck Baltimore Md.	
24D. LOCATION (City, town, or county)					
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Aslington J. Phillips 1727 N. Monro	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7526		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7526	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Evelyn Ford		2. DATE AND HOUR OF DEATH 8/2/67 10:40 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3212 AUCHENTOROLY TERRACE			
5. SEX F	6. RACE N N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3-18-18	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME MARSHALL THOMAS		14. MOTHER'S MAIDEN NAME EDNA LAWS		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 320-63285		17. INFORMANT Blanche Conway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 022X1 D		CAUSE OF DEATH Ventricular Fibrillation Hemorrhage Aortic Aneurysm, Aorta		ADDRESS 395 Monkey INTERVAL BETWEEN ONSET AND DEATH 10 min 70 min 28 yrs	
19A. DATE OF OPERATION 8/2/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Aneurysm, Aorta		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (Floyd T. Bryan) attended the deceased from 8/1 1967 to 8/2 1967, that (I) (Floyd T. Bryan) last saw the deceased alive on 8/2 1967 and that in (my) (Floyd T. Bryan) opinion death occurred on the date and hour and from the causes stated above. (I) (Floyd T. Bryan) (did) (Floyd T. Bryan) view the body after death.					
23A. SIGNATURE Floyd T. Bryan M.D.				23B. DATE SIGNED 8/2/67	
23C. PHYSICIAN'S NAME (Type) FLOYD T. BRYAN		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Moore St.	

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 3. **Results**
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The body of John Singletary was released as non-medical by Dr. Spitz
OF THE Medical Examiner's Office
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7527		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7527	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Singletary		2. DATE AND HOUR OF DEATH 8/4/67 1:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		5. AGE (in years lost birthday) 38	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hosp.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS 8-02		6. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) separated		8. DATE OF BIRTH 6/13/29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY -		9. AGE (in years lost birthday) 37	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SINGLETARY, JOHN	
14. MOTHER'S MAIDEN NAME HORNE, GLADYS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. D	
17. INFORMANT Pauline Giles		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Alcoholic Liver disease	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from July 1, 1967 to August 4, 1967. that (I) (we) last saw the deceased alive on 8/4/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE G. Michael Vincent M.D.		23B. DATE SIGNED 8/4/67	
23C. PHYSICIAN'S NAME (Type) G. Michael Vincent		23D. ADDRESS G. MICHAEL VINCENT, M.D. Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 8-9-67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Cheryl Wilson 1000 Brantley	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7528	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 7528 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GARNER, ERNEST THURMAN Sr.			2. DATE AND HOUR OF DEATH 08-05-67 11:30P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY PASADENA, MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA, MARYLAND D. STREET ADDRESS (If rural, give location) ROYAL BEACH RD., 60A RT 5		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 09-22-02	9. AGE (In years last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE LT., - CENTRAL
10B. KIND OF BUSINESS OR INDUSTRY POLICE DEPT.			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME THOMAS A GARNER			14. MOTHER'S MAIDEN NAME ELSIE GRUPT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 44 9747	17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS A		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 20 min		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 22 19 67 to AUGUST 5 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 5 19 67 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <i>Ramon Suarez, M.D.</i>				23B. DATE SIGNED 8-5-67	
23C. PHYSICIAN'S NAME (Type) RAMON SUAREZ		23D. ADDRESS ST. AGNES HOSPITAL-WILKENS & CATON			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/9/67	24C. NAME of CEMETERY or CREMATORY Loudon Pk. Cem.	24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.		

10:30

Page 1

RECEIVED, 10:30 AM

TO: THE DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text]

[Illegible text]

[Illegible text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-512		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7529	
BIRTH NO. 67 7529		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		JESSE D. THOMPSON		August 6 1967 1:25 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
36 FRANKLIN SQUARE HOSPITAL		MARYLAND 27-19			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE Zone 15			
		D. STREET ADDRESS (If rural, give location)			
		5714 KEY AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
M	W	MARRIED	3/20/96	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		Postal Trans. Govt.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
LEO THOMPSON		CATHERINE COLLINS		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 1918		217-40-324		NETTIE THOMPSON 'same'	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		since 1966	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Congestive Heart Failure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 8/6/67 to 8/6/67, that (I) (we) last saw the deceased alive on 8/6/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				8/6/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
AMABLE A. MENDEZ M.D.		Franklin Square Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/10/67		Balto. National Cemetery	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 7 1967		R. E. Farley, Jr.		Leonard J. Ruck Inc, Balto. Md.	

1912

OK

Postage paid, Jan.



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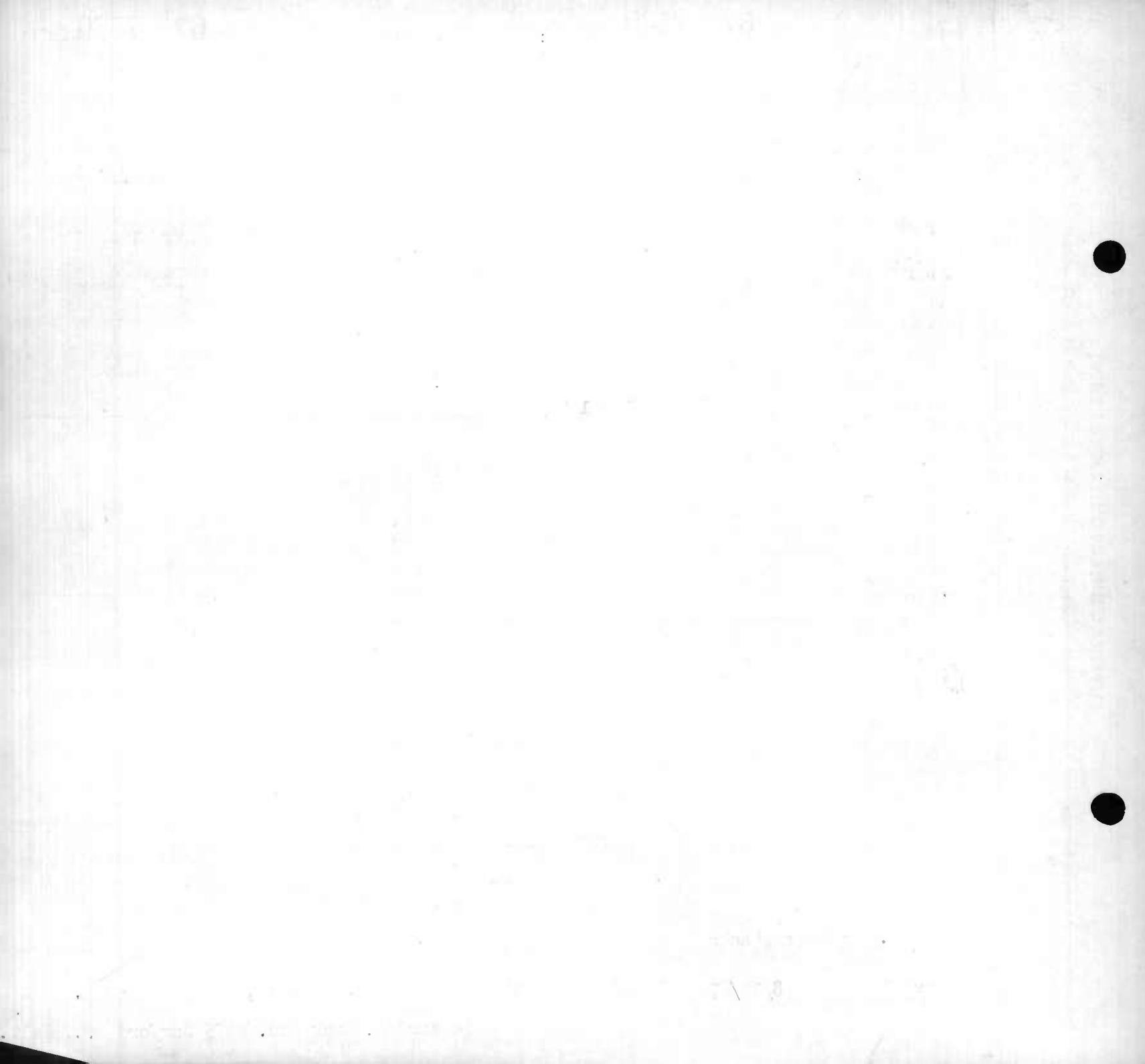
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Postage paid, Jan.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

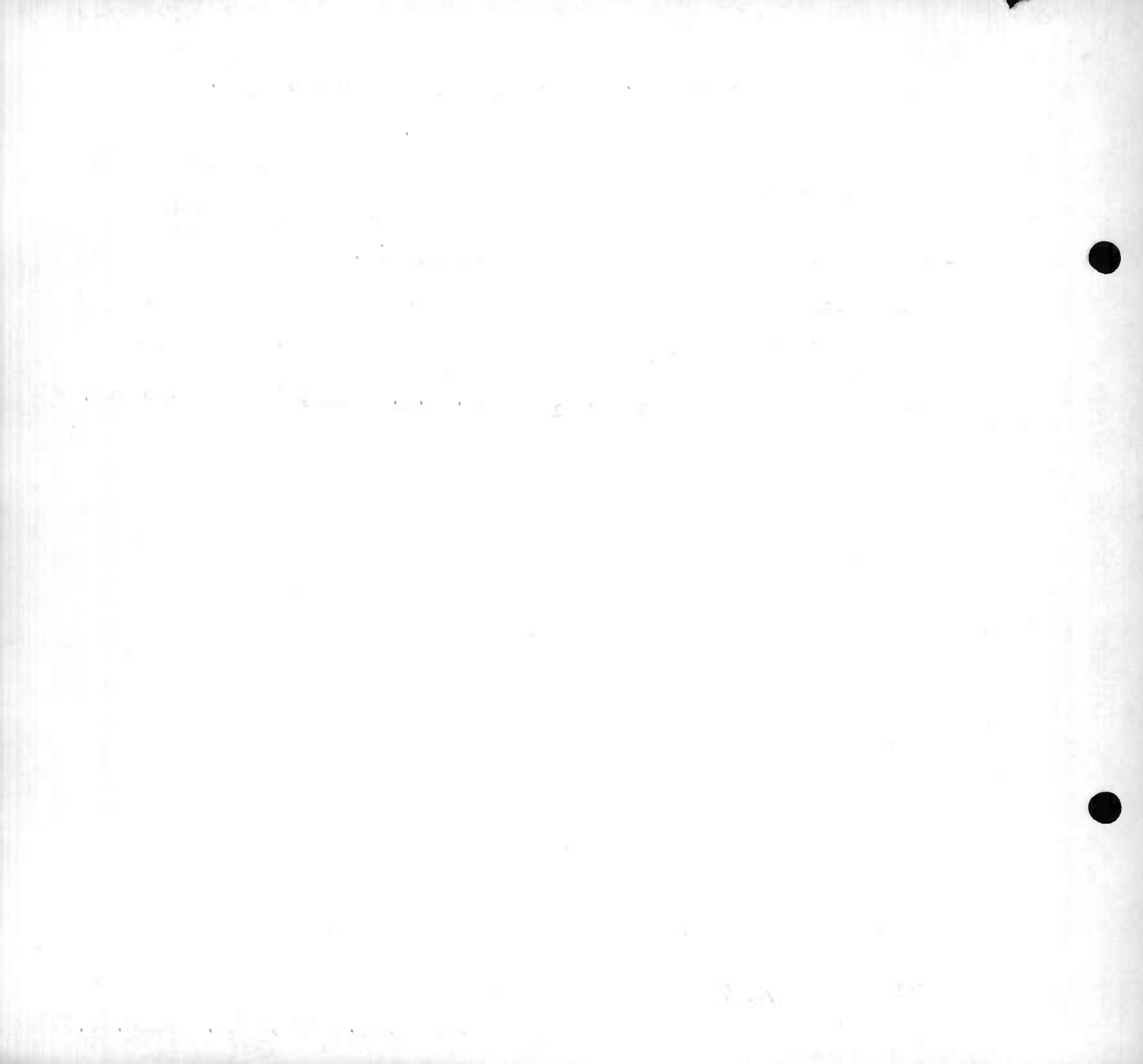
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7530	
BIRTH NO. 67 7530		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VINCENT F. GALLIANO		2. DATE AND HOUR OF DEATH 6 AUG. 1967 9:47 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 48		A. STATE B. COUNTY MARYLAND. SCHUYLKILL			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE. 27-03			
		D. STREET ADDRESS (If rural, give location) 3407 ECHODALE AVE.			
5. SEX Male	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED.	8. DATE OF BIRTH 6 AUG. 1916	9. AGE (In years last birthday) 51	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE PRESIDENT		10B. KIND OF BUSINESS OR INDUSTRY TRASH REMOVAL SERVICE.		11. BIRTHPLACE (State or foreign country) POTTSVILLE PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ANGELO GALLIANO		14. MOTHER'S MAIDEN NAME ERMINIA DENAPOLI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes. 1945 - 1955		16. SOCIAL SECURITY NO. 178017189		17. INFORMANT (WIFE) MARGARET C GALLIANO	
				ADDRESS 3407 ECHODALE AVE. BALTO MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1967 I METASTATIC OSTEO SARCOMA		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 15 FEB 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OSTEO SARCOMA LEFT HIP		20A. AUTOPSY? (Yes or No) NO (refused)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 31 JULY 1967 to 6 AUGUST 1967, that (I) (we) lost saw the deceased alive on 6 AUG 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Frank Fairbanks		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6 Aug 67.	
23C. PHYSICIAN'S NAME (Type) Dr. Frank Fairbanks		23D. ADDRESS MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY Calvary Cemetery	
24D. LOCATION Pottsville, Penna.		24E. ADDRESS			
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR R. B. Fairbanks		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd., Ba	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

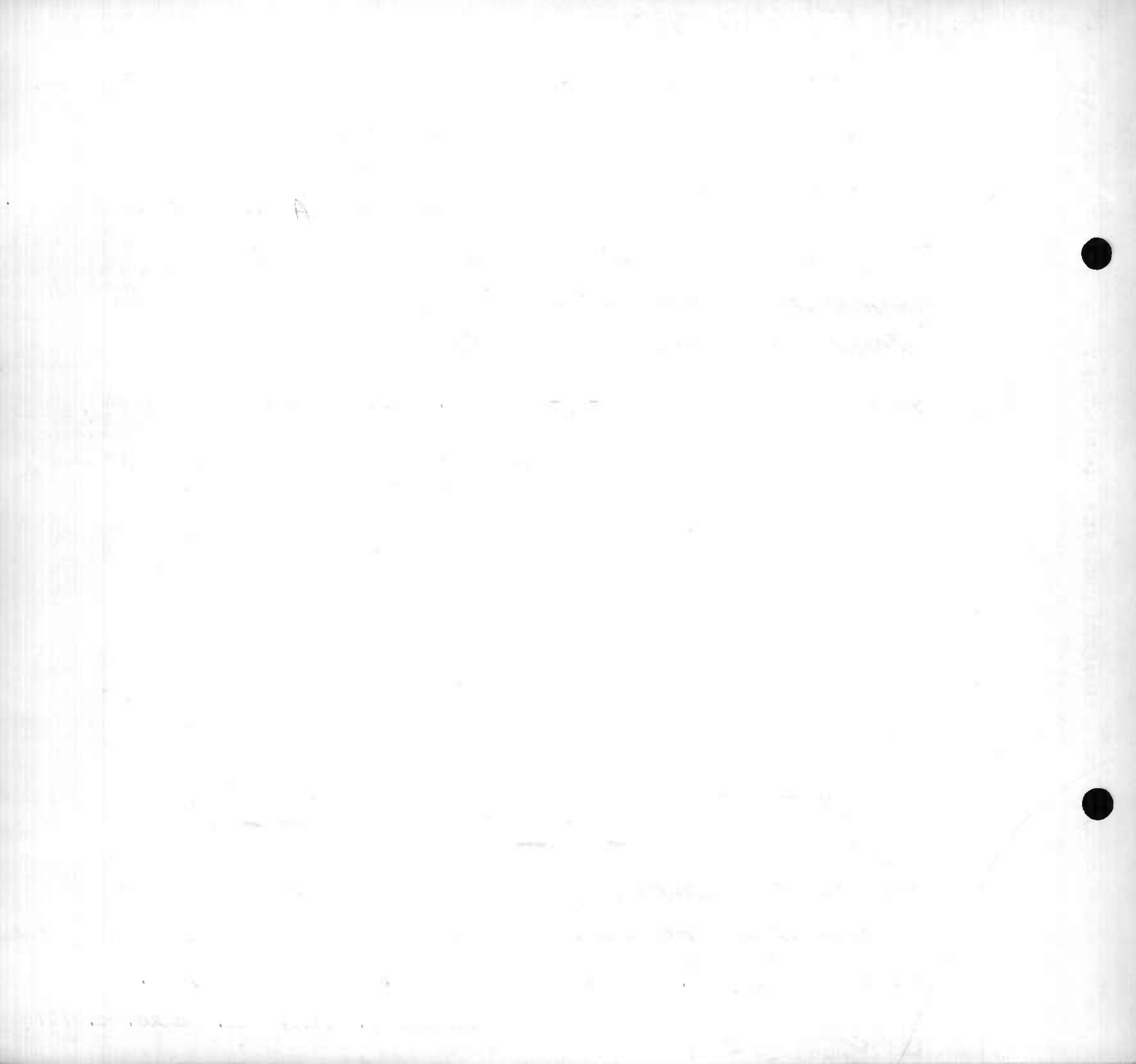
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7531	
BIRTH NO. 67 7531		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Katherine L. Hart (Hall)		2. DATE AND HOUR OF DEATH August 6, 1967. 8 ⁵⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 5514 Edna Avenue		A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214 27-44 D. STREET ADDRESS (If rural, give location) 5514 Edna Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 8, 1883.	9. AGE (In years lost birthday) 84	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Cassilly			14. MOTHER'S MAIDEN NAME Rebecca Dulaney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220167587		17. INFORMANT ADDRESS Mrs. L.E. Wyatt, 3216 Orlando Ave. #34	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arteriosclerotic Cardiovascular Disease.</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension</u>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose Martinez</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/7/67	
23C. PHYSICIAN'S NAME (Type) Jose MARTINEZ		23D. ADDRESS M.D. 100 N. Broadway #231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/9/67	24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7532		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7532	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JAMES THOMAS WHALEN		2. DATE AND HOUR OF DEATH August 5, 1967 8:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-05	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY of MARYLAND Hospital		D. STREET ADDRESS (If rural, give location) 3904 ELMORA AVE (21213)			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/5/13	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Co.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES S. WHALEN		14. MOTHER'S MAIDEN NAME GERTRUDE PARSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 212-07-9081		17. INFORMANT Mrs. Pauline Whalen	
18. 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) METASTATIC CARCINOMA OF THE BLADDER (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 MO.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 31 1967 to August 5 1967. that (I) (we) last saw the deceased alive on August 4 1967 and that In my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Edward W. Campbell Jr.				23B. DATE SIGNED 8/5/67	
23C. PHYSICIAN'S NAME (Type) EDWARD W. CAMPBELL JR.		23D. ADDRESS UNIV. OF MARYLAND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

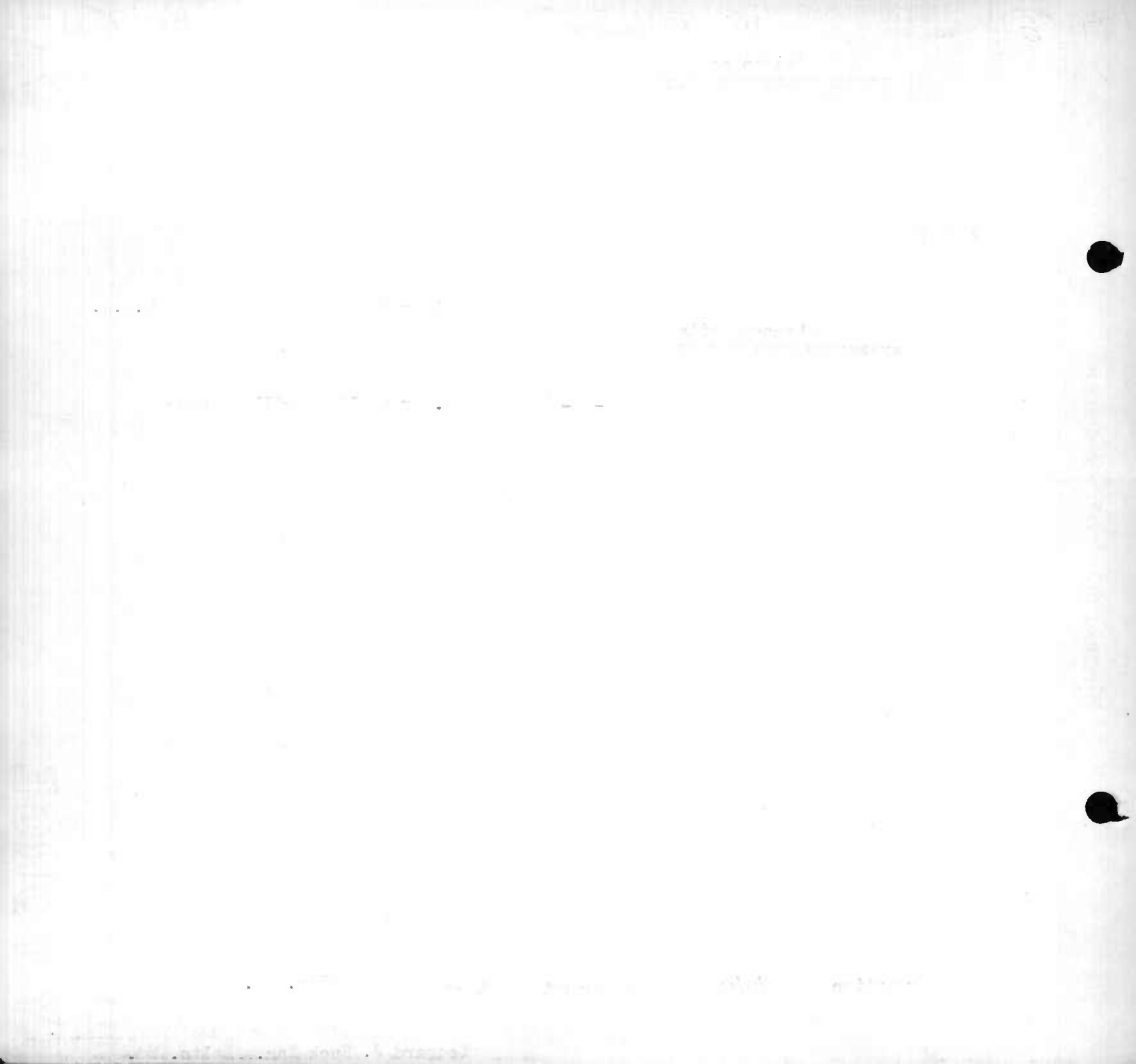
Baltimore City Health Department				Registered No. 67 7533	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 7533 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) JACK J. CAMMARATA			2. DATE AND HOUR OF DEATH 8/5/67 8:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-10 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21224 6. STREET ADDRESS (If rural, give location) 146 S. BOWLIN ST.		
7. SEX M	8. RACE W	9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	10. DATE OF BIRTH 5/24/25	11. AGE (In years last birthday) 42	12. CITIZEN OF WHAT COUNTRY? AMERICA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISKET MANAGER NEWSPAPER			11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		
13. FATHER'S NAME JACK CAMMARATA			14. MOTHER'S MAIDEN NAME JENNIE — Encandlia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2			16. SOCIAL SECURITY NO. 219-01-2194		
17. INFORMANT Mrs. Dorothy Cammarata			ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 42011 I			CAUSE OF DEATH Ventricular Fibrillation		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH Anterograde Myocardial Infarction		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 10 1967 to August 5 1967, that (I) last saw the deceased alive on 8/5 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE W. H. Oehlert, Jr.				23B. DATE SIGNED August 5, 1967	
23C. PHYSICIAN'S NAME (Type) WILLIAM H. OEHLERT, JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			

ATTEMPTED

FUNERAL DIRECTOR: IMPORTANT

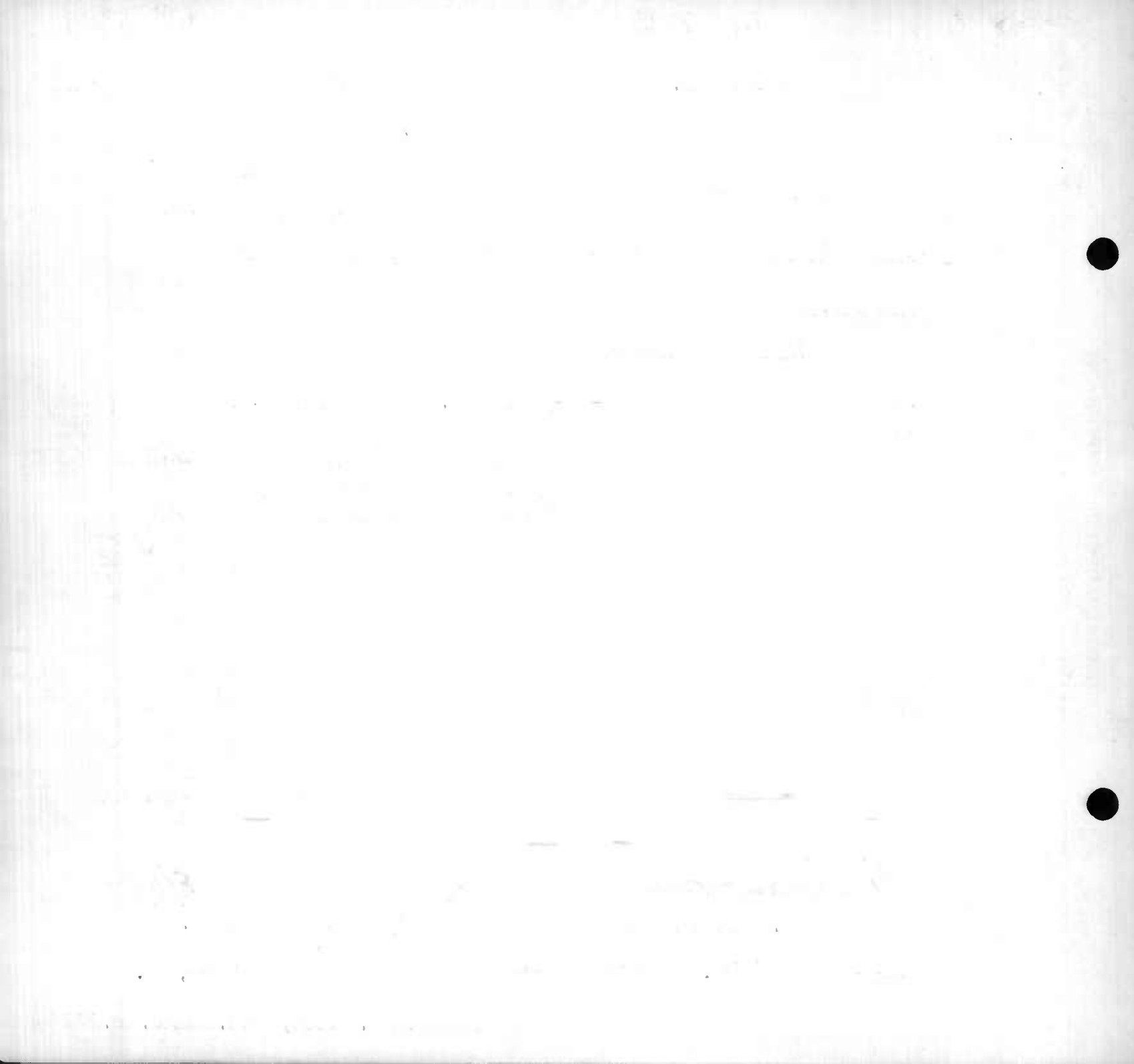
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7534	
BIRTH NO. 67 7534		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Saidee Mae		2. DATE AND HOUR OF DEATH 8/6/67 12.00 p.m.	
1. NAME OF DECEASED (Type or Print) Saidee Mae		2. DATE AND HOUR OF DEATH 8/6/67 12.00 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		A. STATE MARYLAND B. COUNTY 21206			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 5904 PLAINFIELD AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/12/1910	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) California	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Chancey White		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-26-0420		17. INFORMANT Mr. Bramwell Terrill ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) metastatic carcinoma from breast		3 yrs.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12/1967 to 8/6/1967 , that (I) (we) lost saw the deceased alive on 8/6/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type) A. Ullrich		23D. ADDRESS M.D. 6821 REISTERTOWN RD			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/9/67		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) Balto. Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS Balto. Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

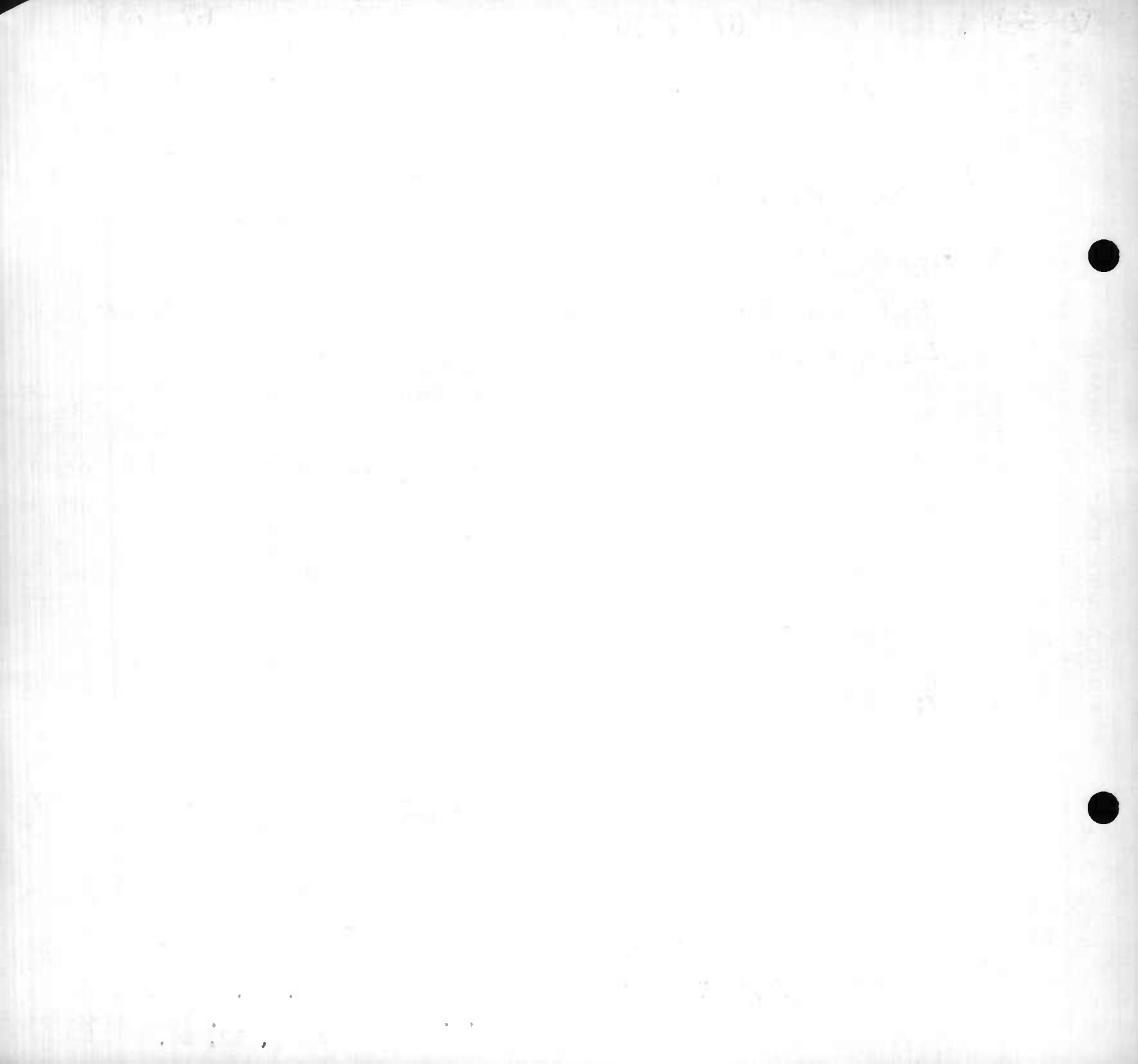
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 7535		67 7535	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Alice B. Bundy			8/6/67 5:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Md.		
1527 Argonne Drive			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 9-82		
			D. STREET ADDRESS (If rural, give location)		
			1527 Argonne Drive		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	Widow	March 22, 1886	81	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			Delaware		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Theodore Howard			Martha ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			220-14-5388		Mrs. Edith Chenoweth (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 I			Myocardial Infarction		Immediate
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Anteriosclerotic Cardio- vascular disease		10 years
			(B) DUE TO		
			(C) DUE TO		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>April 1967</u> to <u>August 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
<u>A. Allan Spier</u>			8/6/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
A. Allan Spier			1501 Pentridge Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/9/67		Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 7 1967		Robert E. Farley, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 7536		Baltimore City Health Department		67 7536	
BIRTH NO.		67 7536		Registered No.	
M.E. CASE NO.		67 7536		Certificate of Death	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KATHERINE D. VAN DANIKER		AUGUST 5, 1967		8:26 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND		B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE TOWSON - 21204	
		D. STREET ADDRESS (If rural, give location)		27 ACORN CIRCLE APT 2053-00	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
FEMALE	WHITE	NEVER MARRIED	09/03/04	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
RETIRED - TEACHER EDUCATION			MARYLAND	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
LEON R. VAN DANIKER		LAURA GIVENS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
			MILDRED VAN DANIKER		27 ACORN CIRCLE APT 20
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 I		(A) MYOCARDIAL INFARCT		20 hours	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 25 1967 to AUGUST 5 1967, that (I) (we) lost saw the deceased alive on AUGUST 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Enrique Cipriani		8/5/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ENRIQUE CIPRIANI		33rd AND CALVEAT STS.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/9/1967		Woodlawn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 10 1967		H.W. Jenkins		& Sons Co. 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7537		BALTIMORE CITY VAHS DEPT		Registered No. 67 7537	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Granville Charles Swope, Jr.		Swope, Grandville, Dc 8 - 4-67 8:15 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, give rural and give township)		D. STREET ADDRESS (If rural, give location)	
Union Memorial Hosp		Mainland		Balto 27-14	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M		W		Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Insurance - RETIRED		BROKER		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GRANVILLE C. SWOPE, SR.		NELLIE KINGSLEY		USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES		WW II 212-01-0567		HARRY F. SWOPE, JR. 637 DEEP DENE RD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN DEATH AND DEATH	
ANTECEDENT CAUSES		(A) LIVER FAILURE		SOLAP	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) U.G.I. bleeding due to rupture of esophageal varices			
		(C) Liver cirrhosis + peptic ulcer of stomach			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		none	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7-21, 7-29		U.G.I. bleed. 2 blood clots		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., if or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-19 1967 to 8-4 1967, that (I) (we) last saw the deceased alive on 8-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
MONTAGUE				8-4-67.	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MONTAGUE				Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/7/1967		Druid Ridge	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 7 1967		R. L. G. 2, Fairview		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Pikesville, Balto. Co.,		Md.			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7538

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GUY L. COOK

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1967 11:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1608 E. 30th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2/4/1891

9. AGE (In years
last birthday)

76

10. Under 1 Yr. 11. Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired-Steelworker

10B. KIND OF BUSINESS OR INDUSTRY

Production

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Cook

14. MOTHER'S MAIDEN NAME

Julia Moomaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-01-6363

17. INFORMANT

ADDRESS

Mrs. Janet Bennett, 1608 E. 30th St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

August 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/7/1967

23C. NAME of CEMETERY or CREMATORY

Parkwood

23D. LOCATION

(City, town, or county)

(State)

Parkville, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

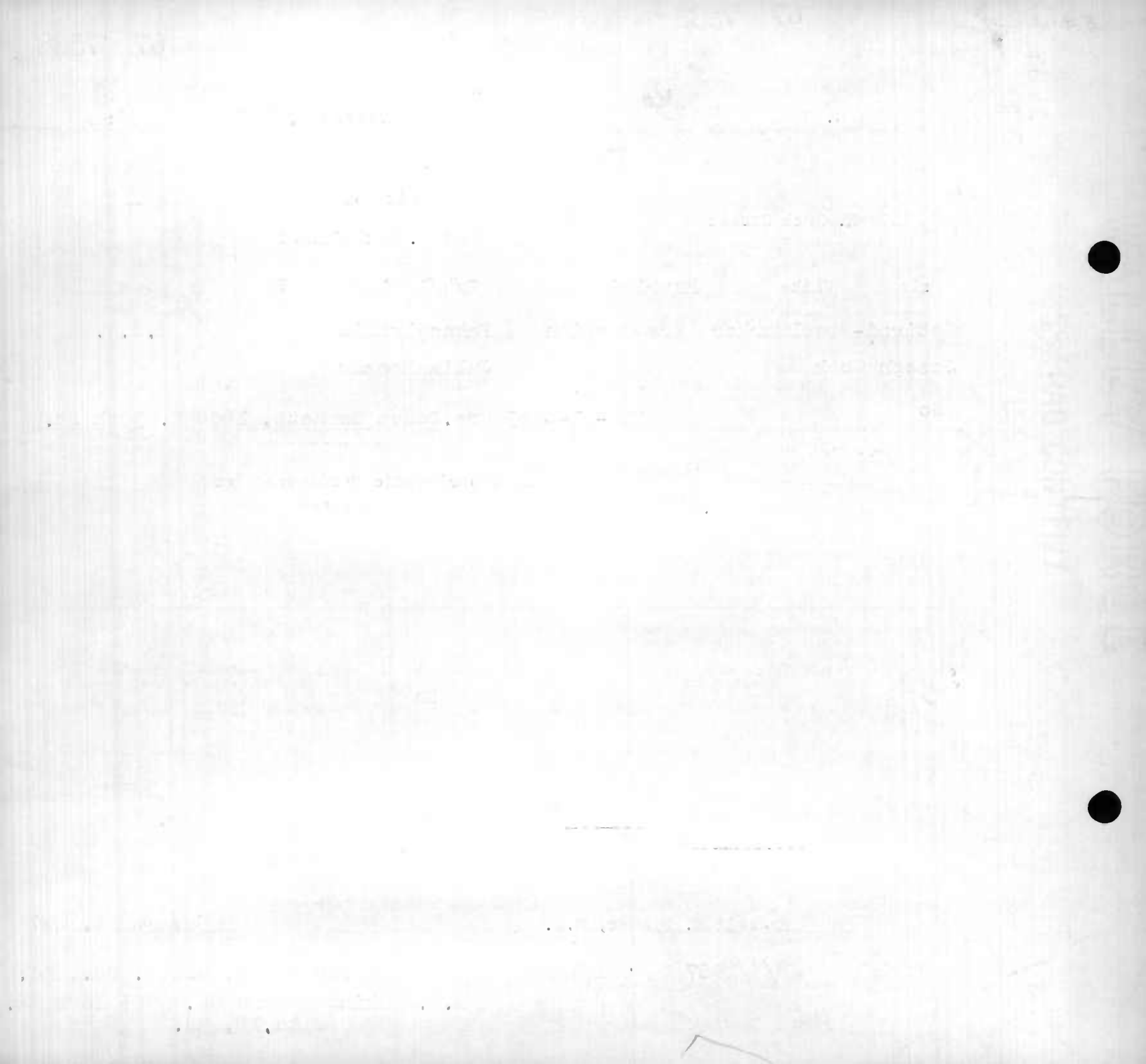
ADDRESS

AUG 7 1967

Robert E. Fisher, M.D.

H.W. Jenkins & Sons Co. 4905 York Rd.

Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 7539		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7539	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.		(CARL WILLIAM MOLTER)			
1. NAME OF DECEASED (Type or Print)		Molter, Carl William		2. DATE AND HOUR OF DEATH 8/4/67 11:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial		A. STATE Md		B. COUNTY Balt. City	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Balt.		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS 2223 Kentucky Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4/4/11	9. AGE (In years last birthday) 5-6	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY Faith Evangelist		11. BIRTHPLACE (State or foreign country) Ohio Hamilton	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Molter		14. MOTHER'S MAIDEN NAME Anna Ansbach	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220 44 1358		17. INFORMANT Mrs Naomi I. Molter 2223 Kentucky	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X1		CAUSE OF DEATH (A) Resp & cardiac arrest (B) Massive CVA (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8:45 pm 8/4/67 to 11:00 pm 8/4/67, that (I) (we) last saw the deceased alive on 8/4/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry J. Weckesser		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/67	
23C. PHYSICIAN'S NAME (Type) BARRY J. WECKESSER		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME of CEMETERY or CREMATORY Hamilton Memorial Park	
24D. LOCATION Hamilton Ohio					
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213	

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M W C

Minister for the Interior
U.S. Department of the Interior

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U.S. Department of the Interior

Division of Land

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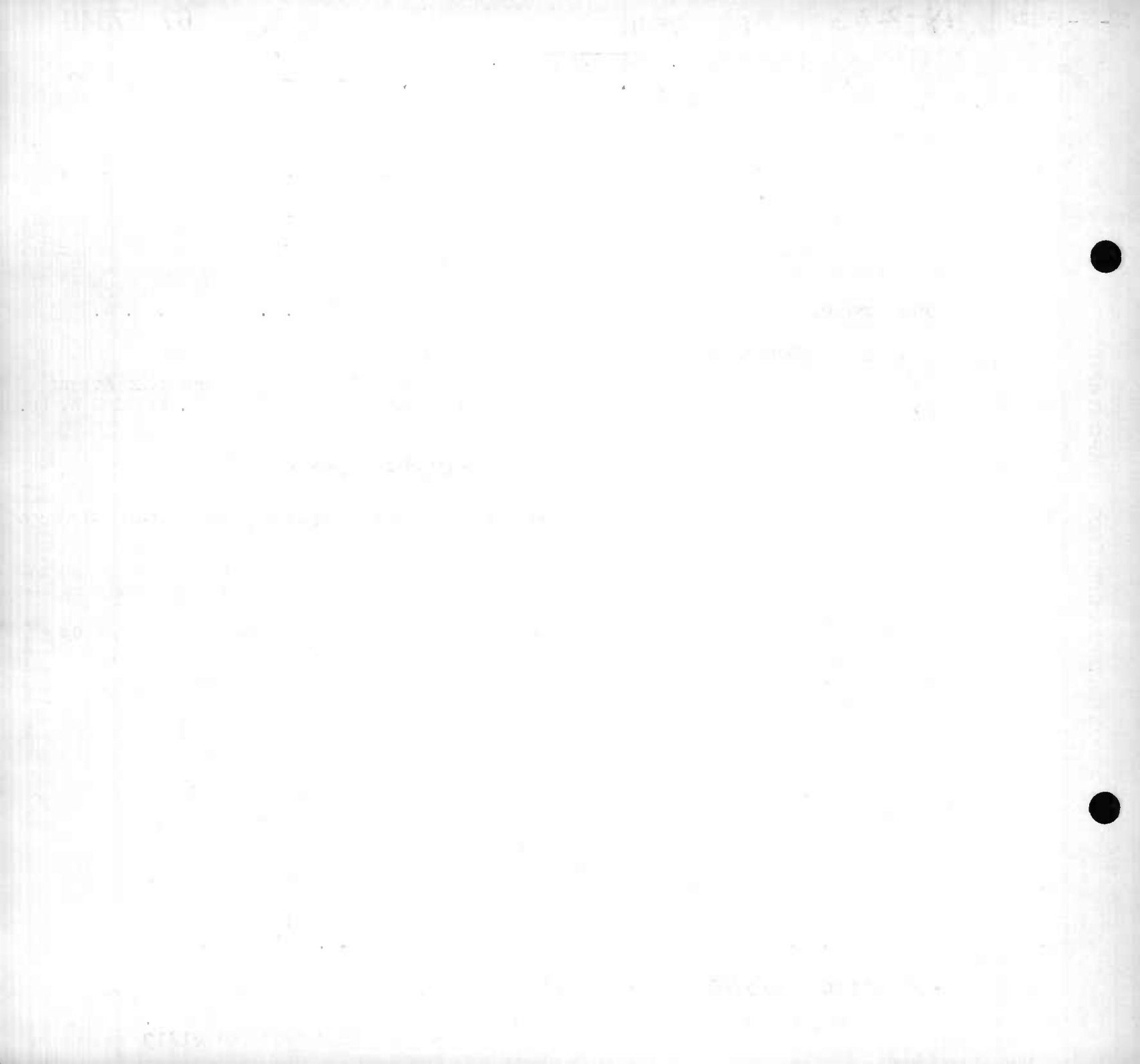
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-233		67 7540		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7540	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HERBERT M. NEUSTADT Sr.		8-3-67 915a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 315 Ingelside Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-16-80	9. AGE (In years last birthday) 87	10. CITIZEN OF WHAT COUNTRY? U. S. A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Broker		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New York City N.Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Otto Neustadt				14. MOTHER'S MAIDEN NAME Joanna			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Scott Biggs 355 Rosebank Avenue BCH: Records 4940 Eastern Ave. Baltimore, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.01 CAUSE OF DEATH (A) CARDIAC ARREST (B) ARTERIO SCLEROTIC HEART DISEASE (C) NOT KNOWN				INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BENIGN PROSTATIC HYPERTROPHY 20 YEARS							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (if this hospital) attended the deceased from 4 6 1967 to 8-3 1967, that (if we) last saw the deceased alive on 8-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. R. Norris				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-3-67	
23C. PHYSICIAN'S NAME (Type) J. R. Norris				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/5/67		24C. NAME of CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 7541		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7541	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>MARTHA Ellen Preston</i>		2. DATE AND HOUR OF DEATH <i>August 4, 1967 7:60 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>2112 Pulaski St</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO MD</i>			
		D. STREET ADDRESS (If rural, give location) <i>BALTO MD</i>			
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>2/14/1898</i>	9. AGE (In years lost birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTO County</i>	
13. FATHER'S NAME <i>Brisco Phillip</i>		14. MOTHER'S MAIDEN NAME <i>Mary Catherine Phillip</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Daughter</i>	
				ADDRESS	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Uremia</i> DUE TO (B) <i>Hypertensive cardio</i> DUE TO <i>Vascular Disease</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> <i>2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 7 1965</i> to <i>Aug 4 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug 4 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Franklin Phillips</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/5/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>G. Franklin Phillips</i>		23D. ADDRESS <i>558 McMechen St. Balto. Md. 8/5/67</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/8/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn</i>	
				24D. LOCATION (City, town, or county) (State) <i>BALTO City</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Theodore D. Long</i>	
				ADDRESS <i>2701 Edmondson Ave</i>	

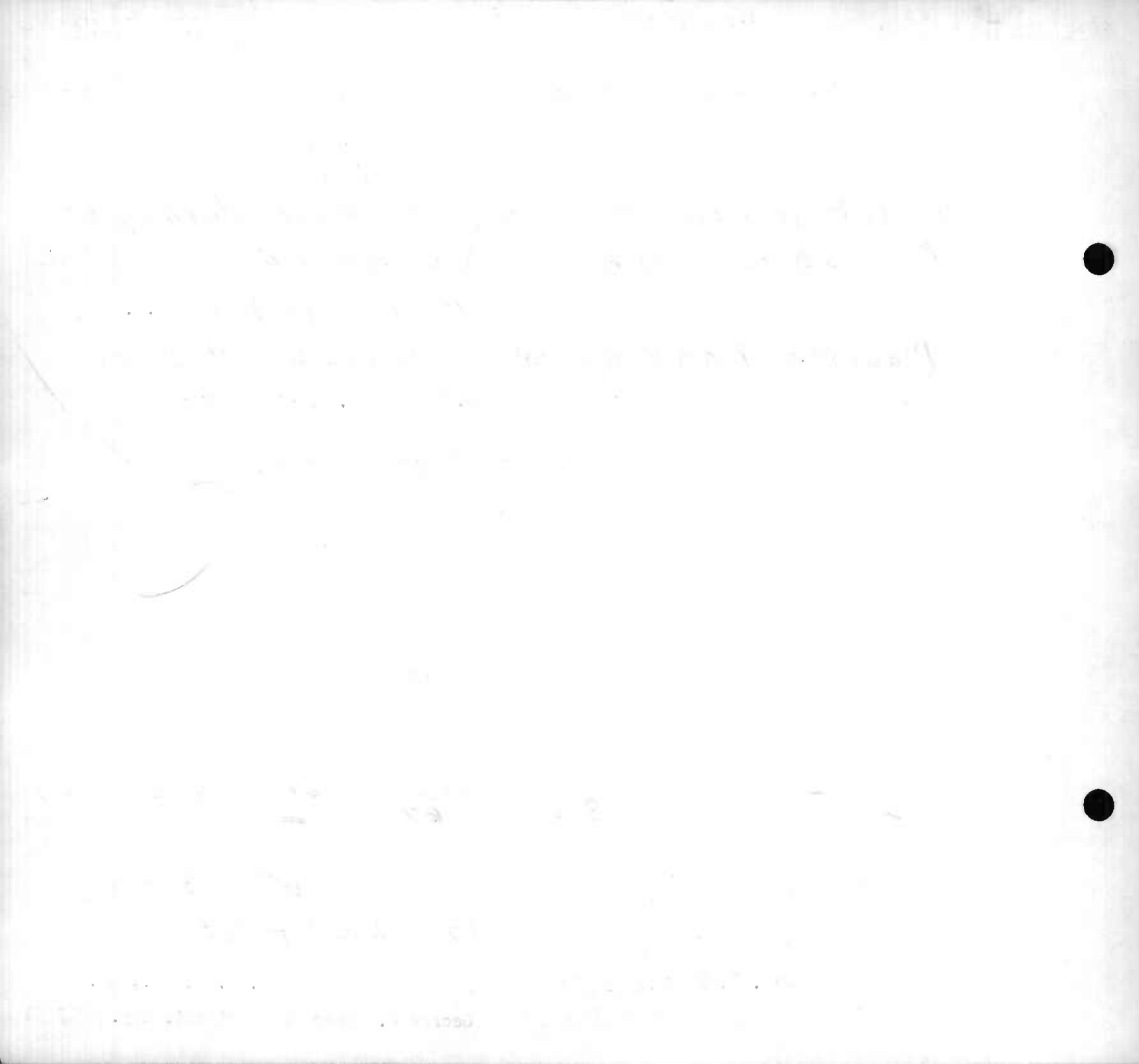
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-15250 67 7542		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7542 4	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sue Lynn Rankins		August 6, 1967 11:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore			
D. STREET ADDRESS (If rural, give location)		23 East Barney St.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
F.		White		N.B.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
None		None		8/6/1967 N.B.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Maurice Rankins, Sr.		Sarah Carder		N.B.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		6. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mr. Maurice N. Rankins Same	
18. 761.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Pro lapse of Cord.		20 minutes	
(B) DUE TO Anoxia.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
0		0		No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that at (this hospital) attended the deceased from 8-6 19 67 to 8-6 19 67 , that we (we) last saw the deceased alive on 8-6 19 67 and that in we (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Honorway M.D. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 8/7/67			
23C. PHYSICIAN'S NAME (Type) Iraj - Honorvar M.D.		23D. ADDRESS 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 7, 1967		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hwy. (21225)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7543		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7543	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BRANDENBURGER, Anna L.		2. DATE AND HOUR OF DEATH 8-7-67 2:25 A.M.	
3. PLACE OF DEATH (In Baltimore, Maryland)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY A.A.C.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 52-00	
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
8. DATE OF BIRTH 2-9-09		9. AGE (In years lost birthday) 58		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Stm. Raskey	
14. MOTHER'S MAIDEN NAME Helena Jasara		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Pts. Chart		ADDRESS		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. INTERVAL BETWEEN ONSET AND DEATH months		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) NO	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
30. I certify that (I) (this hospital) attended the deceased from July 5 1967 to Aug. 7 1967 , that (I) (we) lost saw the deceased alive on 2:25AM AUG. 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
31. SIGNATURE Byung Kap Kang		32. DATE SIGNED 8-7-67		33. PHYSICIAN'S NAME (Type) BYUNG KAP KANG	
34. ADDRESS Bon Secours Hospital		35. NAME OF CEMETERY OR CREMATORY Holy Cross		36. LOCATION (City, town, or county) (State) Baltimore	
37. DATE RECEIVED BY HEALTH DEPT. AUG 8 1967		38. NAME OF REGISTRAR Robert E. Taylor, M.D.		39. FUNERAL DIRECTOR McKee - 737	
40. ADDRESS		41. ADDRESS		42. ADDRESS	

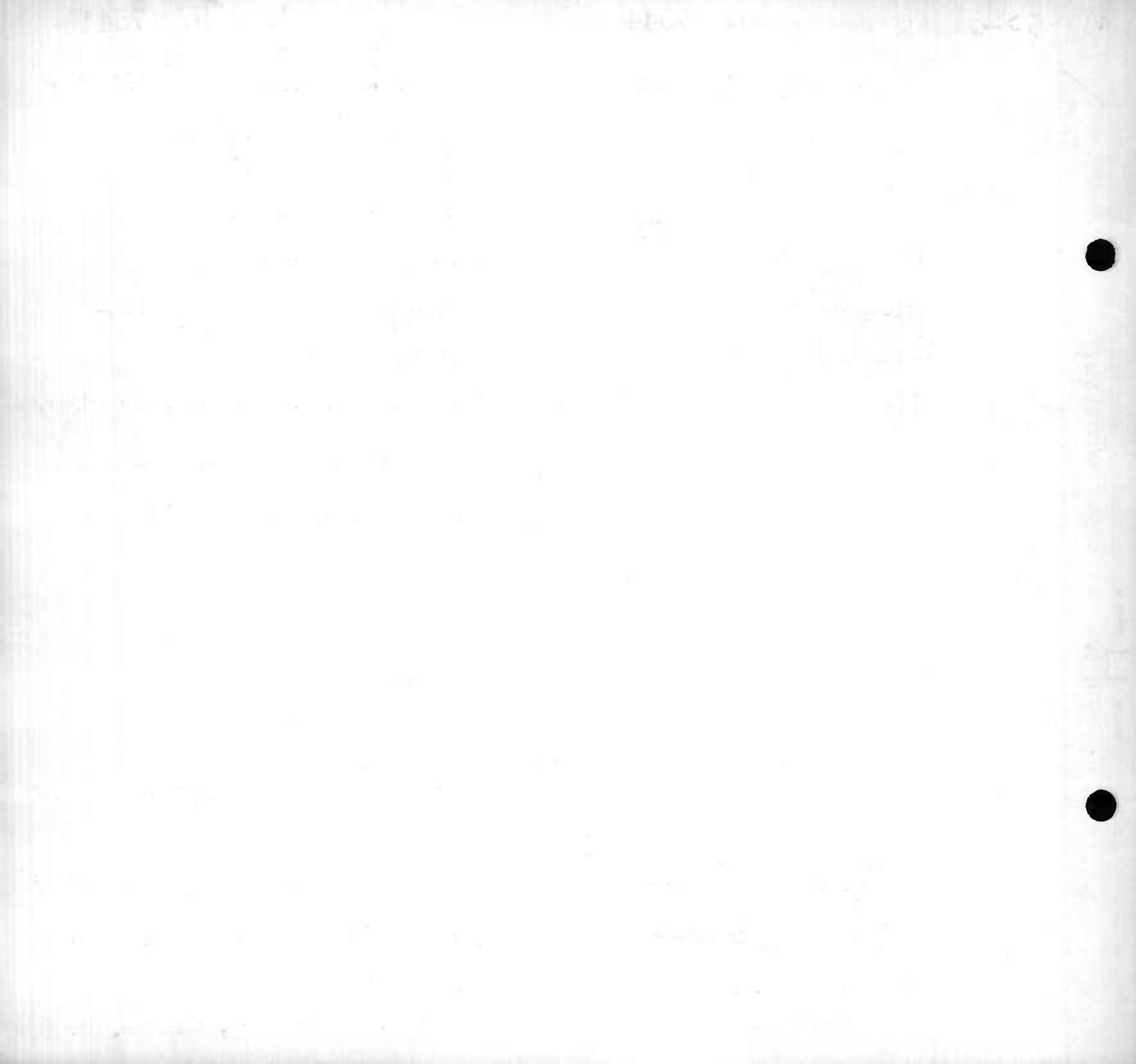
8/15/67 - Correction form from funeral director.

BC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

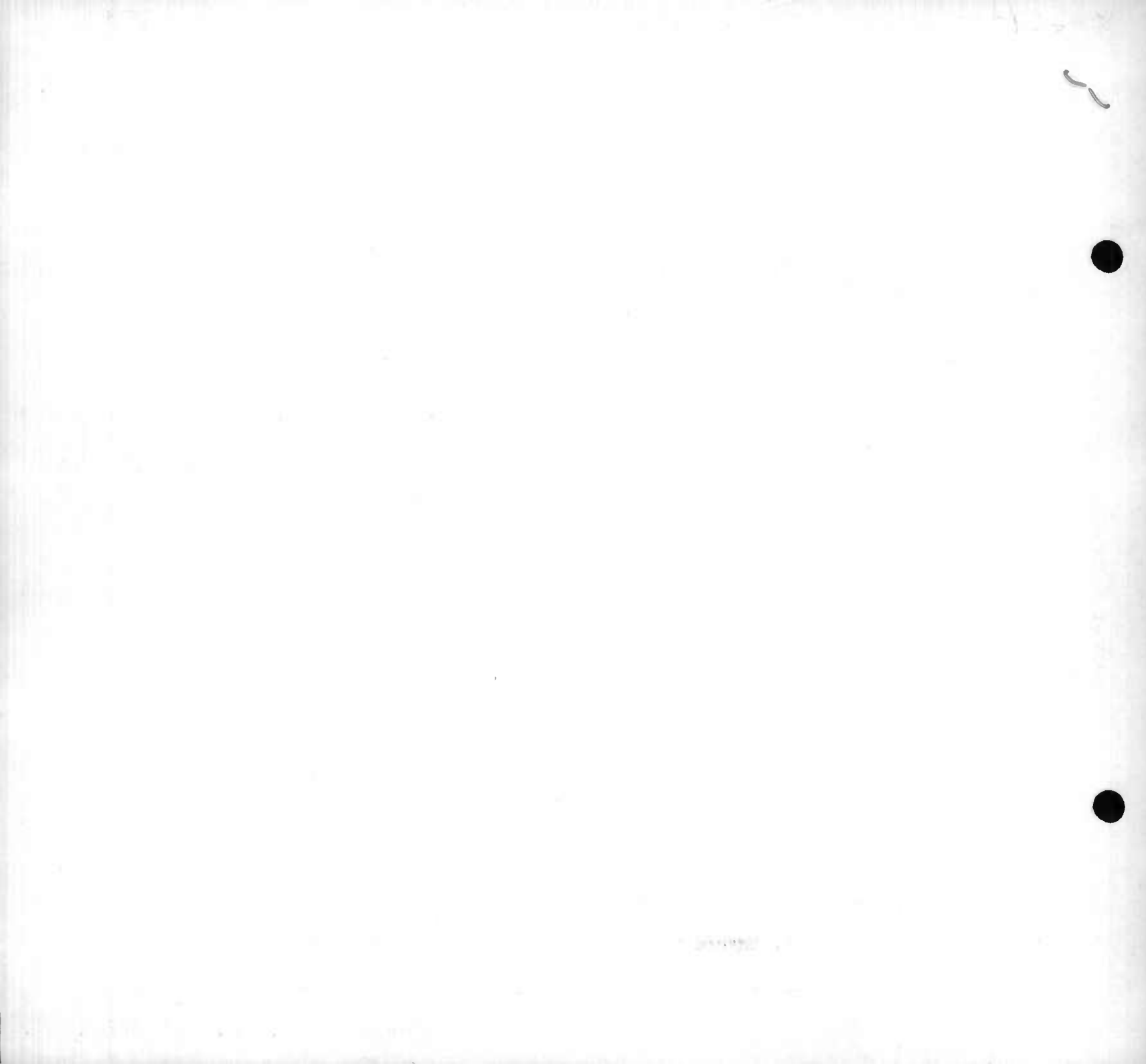
BIRTH NO. 67 7544				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7544	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Monk, Gladys BELLE				2. DATE AND HOUR OF DEATH Aug. 4, 1967 11:50 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. CITY/TOWN Baltimore	
C. CITY OR TOWN (If outside city limits, give RURAL and give township)		D. STREET ADDRESS (If rural, give location)		E. Cedar Lane		53-00	
5. SEX F	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8/15/19	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Campbell Walter				14. MOTHER'S MAIDEN NAME JANNIE O. FERGUSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26-1123		17. INFORMANT ADDRESS Oliver A. Monk, E. Cedar Lane, Kingsville, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 173501				CAUSE OF DEATH (A) Duonian cyst adenocarcinoma (B) Rheumatic heart disease (C)		INTERVAL BETWEEN ONSET AND DEATH 2 years 40 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 25 1967 to Aug. 4 1967 , that (I) (we) last saw the deceased alive on Aug. 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John Graber				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 4, 1967	
23C. PHYSICIAN'S NAME (Type) John Graber		23D. ADDRESS Johns Hopkins Hosp. Balt., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 7, 1967		24C. NAME of CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Harford Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR Howard K. McComas & Son		ADDRESS Abingdon, Md. 21009	



FUNERAL DIRECTOR: IMPORTANT

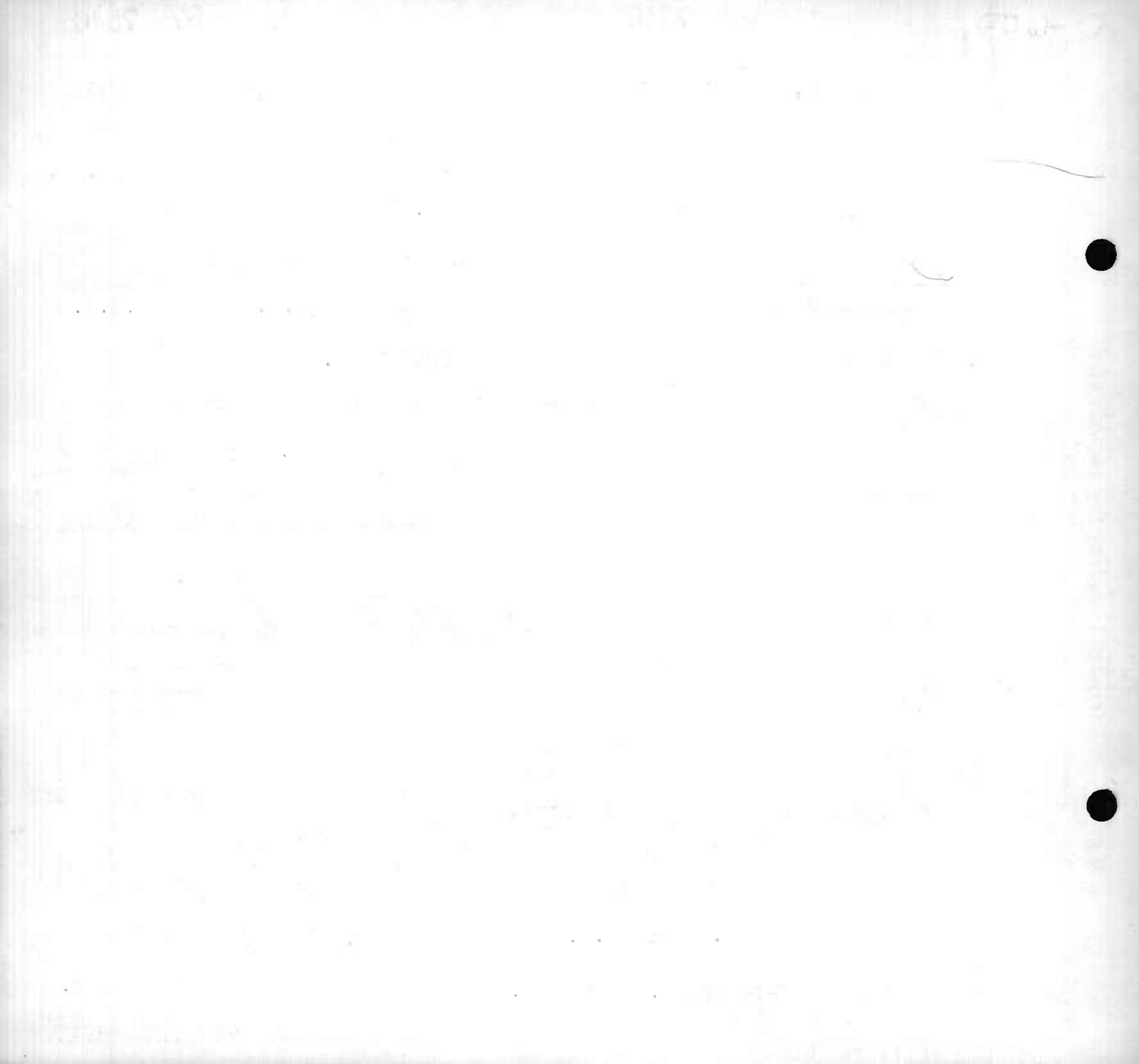
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7545	
BIRTH NO. 67 7545		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ida Rosenbloom		2. DATE AND HOUR OF DEATH August 3, 1967 5 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4213 Woodmere Avenue		C. CITY OR TOWN (If outside city limits, with RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4213 Woodmere Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH March 1901	9. AGE (in years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Sonia Caplan, 2518 Farrington Road #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of pancreas 10 mos.		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from on 8/3/67 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin J. Siontz M.D.				23B. DATE SIGNED 8/3/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/67		24C. NAME OF CEMETERY or CREMATORY (Anshe Emunah) - Aitz Chaim	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Siskema	
25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist. Rd.		25D. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7546	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 7546 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Dwyer, Emma Virginia</u>			2. DATE AND HOUR OF DEATH <u>August 5, 1967</u> <u>7:10</u> AM.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Keswick, 700 W 40th St</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md/</u> B. COUNTY <u>Balts. Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Kingsville</u> D. STREET ADDRESS (If rural, give location) <u>53-00 Mt. Vista Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>9-24-13</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>			11. BIRTHPLACE (State or foreign country) <u>Weehawken, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frank Dwyer</u>			14. MOTHER'S MAIDEN NAME <u>Lucilla S. Cowper</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-10-9703</u>		17. INFORMANT <u>Mary E Wharton</u> ADDRESS <u>Keswick Records</u>
18. <u>465-XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Cardiac arrest</u> DUE TO (B) <u>? Pulmonary embolism</u> DUE TO (C) <u>Multiple sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) This hospital attended the deceased from <u>4-26</u> 19 <u>67</u> to <u>8-5</u> 19 <u>67</u> , that (1) <u>we</u> last saw the deceased alive on <u>8-4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>RK Gundry</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8-5-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard K. Gundry M.D.</u> M.D.				23D. ADDRESS <u>2 W. University Parkway</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-8-1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. John's Epic. Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Kingsville Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Lozada Funeral 2401 Belair Road</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7547

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS H. COTTER

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967 9:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

604 Woodbourne Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

604 Woodbourne Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Feb. 5, 1902

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance man

10B. KIND OF BUSINESS OR INDUSTRY

Welch Bach Corp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Machael Cotter

14. MOTHER'S MAIDEN NAME

Ruth Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

War I

16. SOCIAL
SECURITY NO.

215-05-9197

17. INFORMANT

Hazel M. Cotter (Wife) Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 10/1967

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

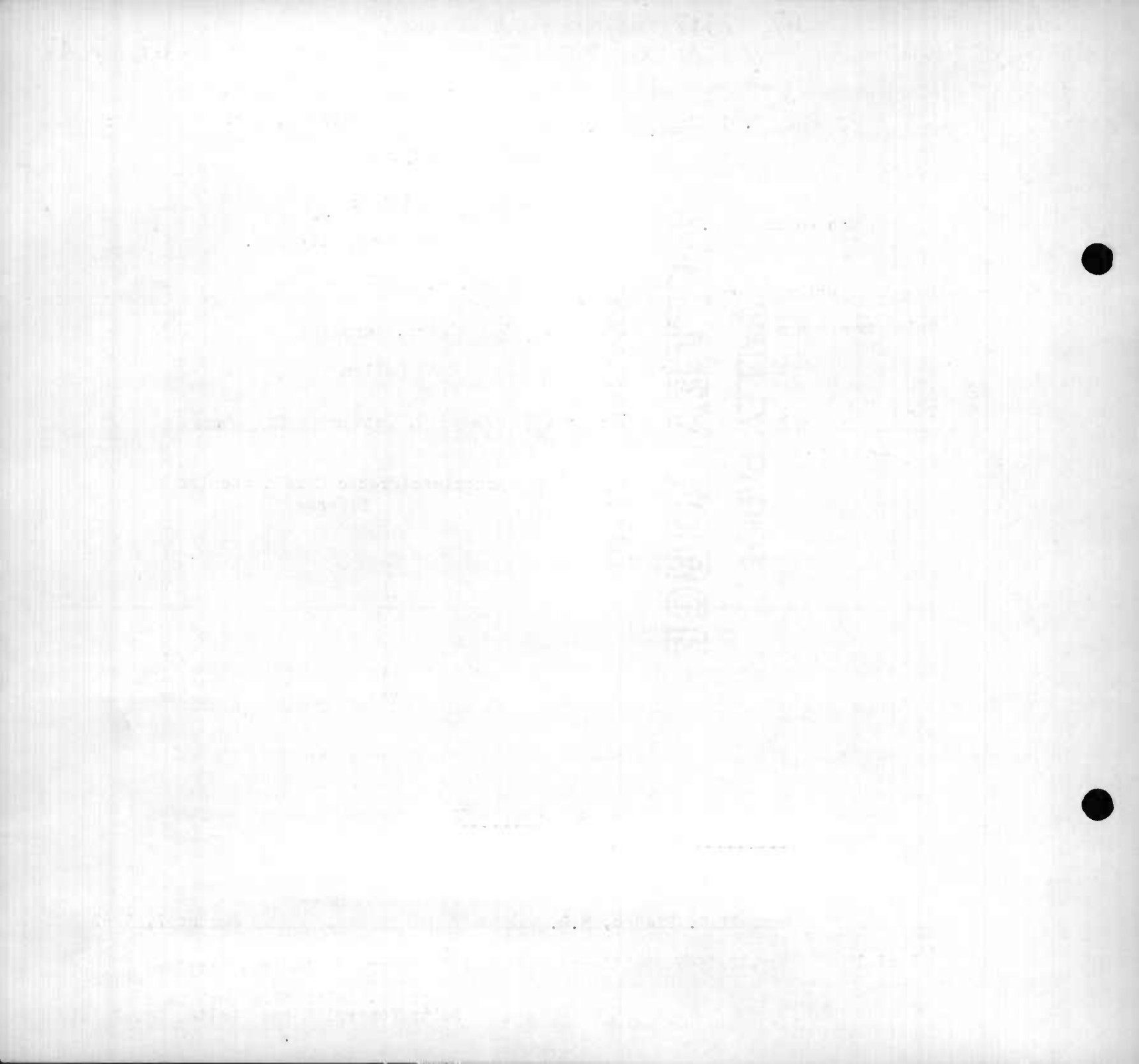
24C. FUNERAL DIRECTOR

ADDRESS

AUG 8 1967

Robert E. Fisher

Eugenia K. Seitz 5209 York Road
Seitz Funeral Home Balto. Md. 2 1212



m-300

67 7548

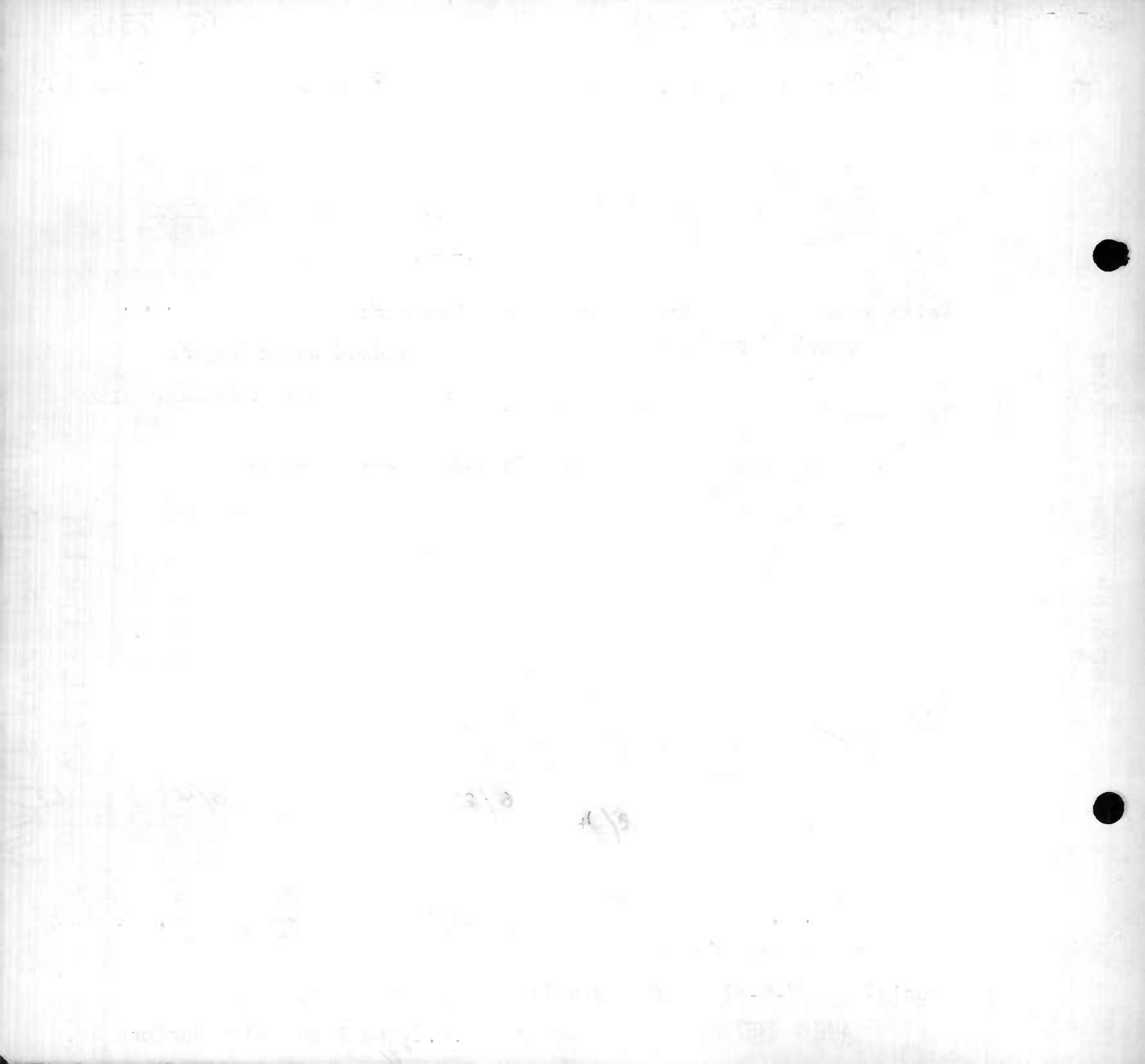
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 7548

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-300		67 7548		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7548	
1. NAME OF DECEASED (Type or Print) MEADE, ROGER E.				2. DATE AND HOUR OF DEATH 8/4/67 6 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY D. STREET ADDRESS (If rural, give location) 9637 OAK SUMMIT AVENUE 21234			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-9-27	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Rep.		10B. KIND OF BUSINESS OR INDUSTRY Fridigaire Corp		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXX Earl P. Meade				14. MOTHER'S MAIDEN NAME XXXXXX Jesse Rogers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO. 062-20-8734		17. INFORMANT ADDRESS BCH; RECORDS 4940 EASTERN AVENUE 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute Leukemia. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Acute Leukemia. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/22 1967 to 8/4 1967, that (I) (we) last saw the deceased alive on 8/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE W. Stan Wilson M.D.				23B. DATE SIGNED 8/4/67		23C. PHYSICIAN'S NAME (Type) DR. W. STAN WILSON M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-67		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gar.		24D. LOCATION (City, town, or county) (State) Balto Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Fidler, M.D.		25C. FUNERAL DIRECTOR C.F. EVANS & SON		25D. ADDRESS 8802 Harford Rd.	

FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 7549		67 7549	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WEBBER, CHARLES GARFIELD			2. DATE AND HOUR OF DEATH 8-4-67 6:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3209 ELMLEY AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED (specify) MARRIED	8. DATE OF BIRTH 08-08-87	9. AGE (in years lost birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES WEBBER			14. MOTHER'S MAIDEN NAME ELIZABETH ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I		16. SOCIAL SECURITY NO. 218 10 4459	17. INFORMANT HARRY HAINES 633 ROCKAWAY BEACH		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary atherosclerosis with myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Statin post-operative		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-22-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute retention urine from BPH		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 7-10-1967 to 8-4-1967 that (X) (we) last saw the deceased alive on 8-4-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Felix J. Martin M.D.			23B. DATE SIGNED 8-4-67		23C. PHYSICIAN'S NAME (Type) FELIX J. MARTIN
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 8/8/67		24C. NAME OF CEMETERY or CREMATORY BALTO. NAT
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967			25B. NAME OF REGISTRAR Robert E. Talbott		25C. FUNERAL DIRECTOR J. G. CONNELLY SONS
24D. LOCATION (City, town, or county) BALTO. MD.			24E. ADDRESS 300 MAC		

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY SP-6 JAL/STP

[Handwritten signature]
[Illegible handwritten text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

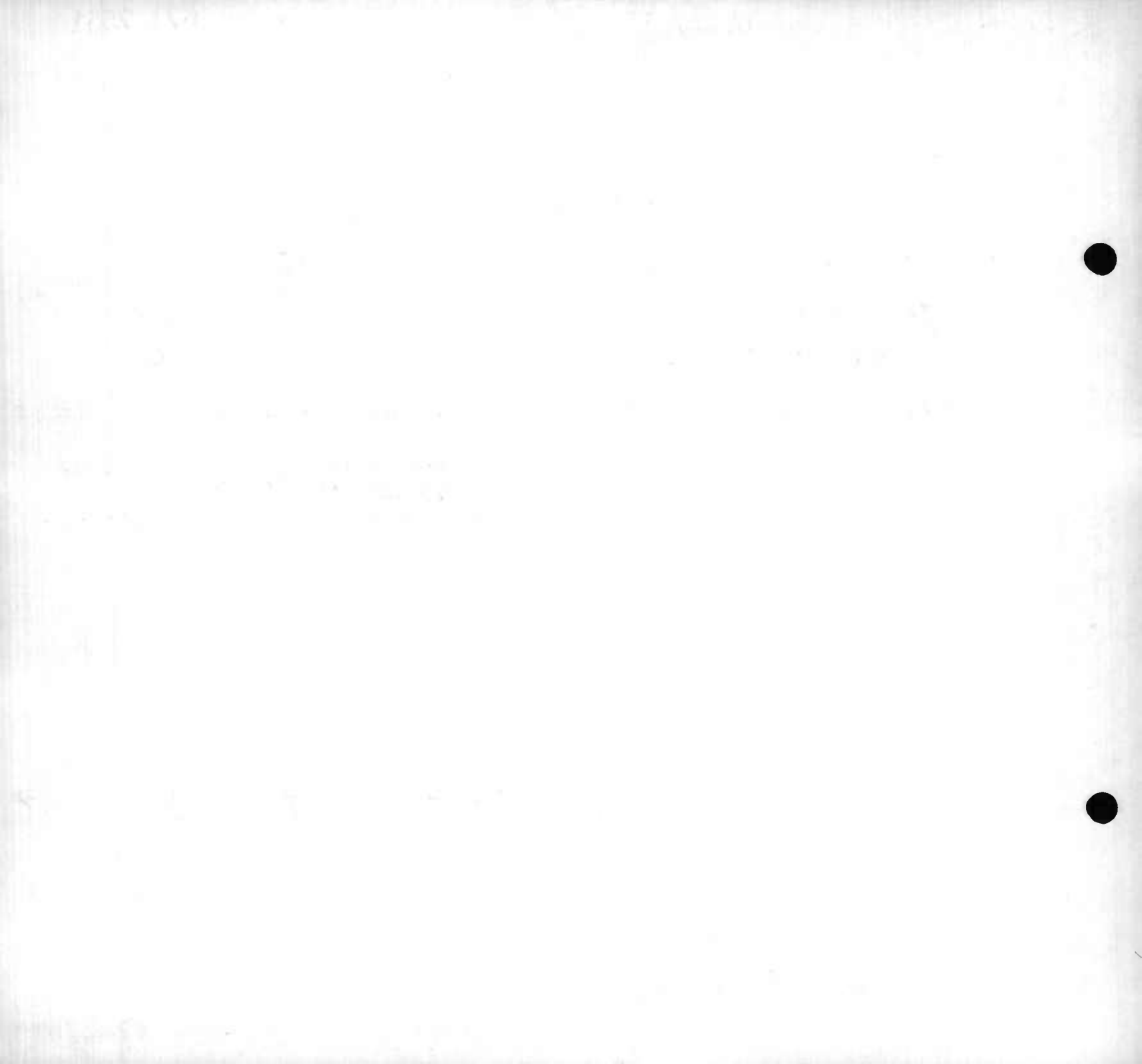
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7550	
BIRTH NO.		67 7550		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELIZABETH FANTASIE		2. DATE AND HOUR OF DEATH 8-6-67 6:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto Co		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1004 H. ST.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED , DIVORCED (specify)	8. DATE OF BIRTH 8/6/1888	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRANK BUTTON			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT JULIUS FANTASIE , 12 TOWNSHIP RD.	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ante Cardiac Hemorrhage		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertension DUE TO		years	
(C) arteriosclerosis DUE TO				years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-3 19 67 to 8-6 19 67 , that (I) (we) last saw the deceased alive on 8-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 8-6-67	
23C. PHYSICIAN'S NAME (Type) NENITA L SUAREZ M.D.				23D. ADDRESS Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN	
24D. LOCATION (City, town, or county) (State) BALTO. M.D.		25A. DATE RECEIVED BY HEALTH DEPT. Aug 15 1967		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7551		67 7551		67 7551	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PAUL KOERMER		Aug 5, 1967 6:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND BALTIMORE		Baltimore 53-00	
5. CHURCH HOME AND HOSPITAL		D. STREET ADDRESS (If rural, give location)		131 RIVERSIDE AVE.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	9-1-1910	52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
TAX ASSESSOR			MARYLAND	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
GERMANUS KOERMER		MARGARET GESSNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
UNK		212-01-9243	THERESA KOERMER ABOVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.11		(A) DUE TO ACUTE MYO CARDIAC INFARCTION & PUL. EDEMA		2 DAYS	
ANTECEDENT CAUSES		(B) DUE TO ARTERIOSCLEROTIC HEART DISEASE		4 YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 4 1967 to Aug 5 1967 that (I) (we) last saw the deceased alive on Aug 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
VENERACIO				Aug 5 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
VENERACIO		CHURCH HOME & HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/9/67		HOLLY HILL	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 8 1967		Robert E. Fisher, M.D.		John J. Connelly, Esq.	
				ADDRESS	
				Essex 21 md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7552	
BIRTH NO. 67 7552		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARRY J. ARMSTRONG II		2. DATE AND HOUR OF DEATH AUG 2 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTO. CITY HOSPITALS		A. STATE MD B. COUNTY BALTO.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK 53-00			
		D. STREET ADDRESS (If rural, give location) 6759 WOODLEY RD.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUG. 29 1911	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLY		10B. KIND OF BUSINESS OR INDUSTRY G. M.		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARRY J. ARMSTRONG SR.			14. MOTHER'S MAIDEN NAME MURRAY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 215-10-6892		17. INFORMANT ADDRESS MARY ARMSTRONG ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction		CAUSE OF DEATH (A) DUE TO Chronic congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		3 years	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-18 1962 to 8-2 1967 , that (I) (we) last saw the deceased alive on 6-6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John V. Conway				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) J. G. Connelly				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/5/67		24C. NAME OF CEMETERY or CREMATORY MEADOW RIDGE	
24D. LOCATION (City, town, or county) (State) BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS J. G. CONNELLY SONS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7553		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7553	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Kellis Johnson			2. DATE AND HOUR OF DEATH Aug. 3, 1967 8:40P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 1105 E. Fayette Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-03 D. STREET ADDRESS (If rural, give location) 618 N. Mount Street		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 2-5-1876	9. AGE (In years lost birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217 09 4793A		17. INFORMANT Mrs. Johnson ADDRESS 1650 W. North Ave.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ASCVD (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Several yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cronic Brain Syndrom			3 yrs.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (XXXXX) attended the deceased from Mar 3, 1967 to Aug. 3, 1967 , that (I) (XXX) last saw the deceased alive on Aug. 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (No) (did) (XXXXX) view the body after death.					
23A. SIGNATURE E Ellsworth Cook				23B. DATE SIGNED Aug. 3, 1967	
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook		23D. ADDRESS M.D. 2431 Maryland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-7-67	24C. NAME of CEMETERY or CREMATORY Arbutus Park	24D. LOCATION (City, town, or county) (State) Balt MD		
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Mrs. Frances A. Hensley ADDRESS 578	

Justified Name . . .

Justified Name . . .

Justified Name . . .

Justified Name . . .

Justified Name . . .

Justified Name . . .

Justified Name . . .

Justified Name . . .

Justified Name . . .

B-260

67 7554

BALTIMORE CITY HEALTH DEPARTMENT

67 7554

BIRTH NO. 64-2309/MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James A. Bucher

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967

4:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

JAMES A. BUCHER

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

FULL NAME OF (If not in hospital or institution, give street
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION

Baltimore

CITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

2004 Lark Hall Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

Aug. 18, 1964

9. AGE (In years
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John R. Bucher

14. MOTHER'S MAIDEN NAME

Faye L. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT (Father)

ADDRESS Maryland

Mr. John Bucher, 2004 Lark Hall Rd. Dundalk,

18. E 929.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia due to drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Pool

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2000 Lark Hall Road

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8 6 67 4:00 ? p.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subject drowned in pool

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/8/67

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7555	
BIRTH NO. 67 7555		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. Mabel C. Aycoth		2. DATE AND HOUR OF DEATH 6 August 1967 12:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Edgemere 33-00 D. STREET ADDRESS (If rural, give location) 2343 Ruth Ave #19			
5. SEX Female	6. RACE CAU.	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-26-00	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. - - - - -
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Myers			
14. MOTHER'S MAIDEN NAME MARY YOUNKER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -			
16. SOCIAL SECURITY NO. 214-24-4379		17. INFORMANT (Son) Allison Aycoth - SAME AS ABOVE - ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 260X1		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Dis DUE TO (B) Chronic Congestive Failure DUE TO (C) Cardiac Arrest (D) Dissecting Aneurysm			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28/67 19 to 8/6/67 19, that (I) (we) last saw the deceased alive on 8/4/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAR		23D. ADDRESS CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/67		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR John E. Sailer		25C. FUNERAL DIRECTOR John J. Duda , 7922 Wise Ave. Dundalk, Md.	

DATE: 11-20-60

1960

BALANCE

3443 15TH AVE

11-20-60 00

USA

6M

WAT. YOUNG

11-24-60 ALIEN

ALBANY, N.Y.

CHARGE CARD

11-24-60

CHARGE CARD

F. C.

11-24-60

WAT. YOUNG

11-24-60

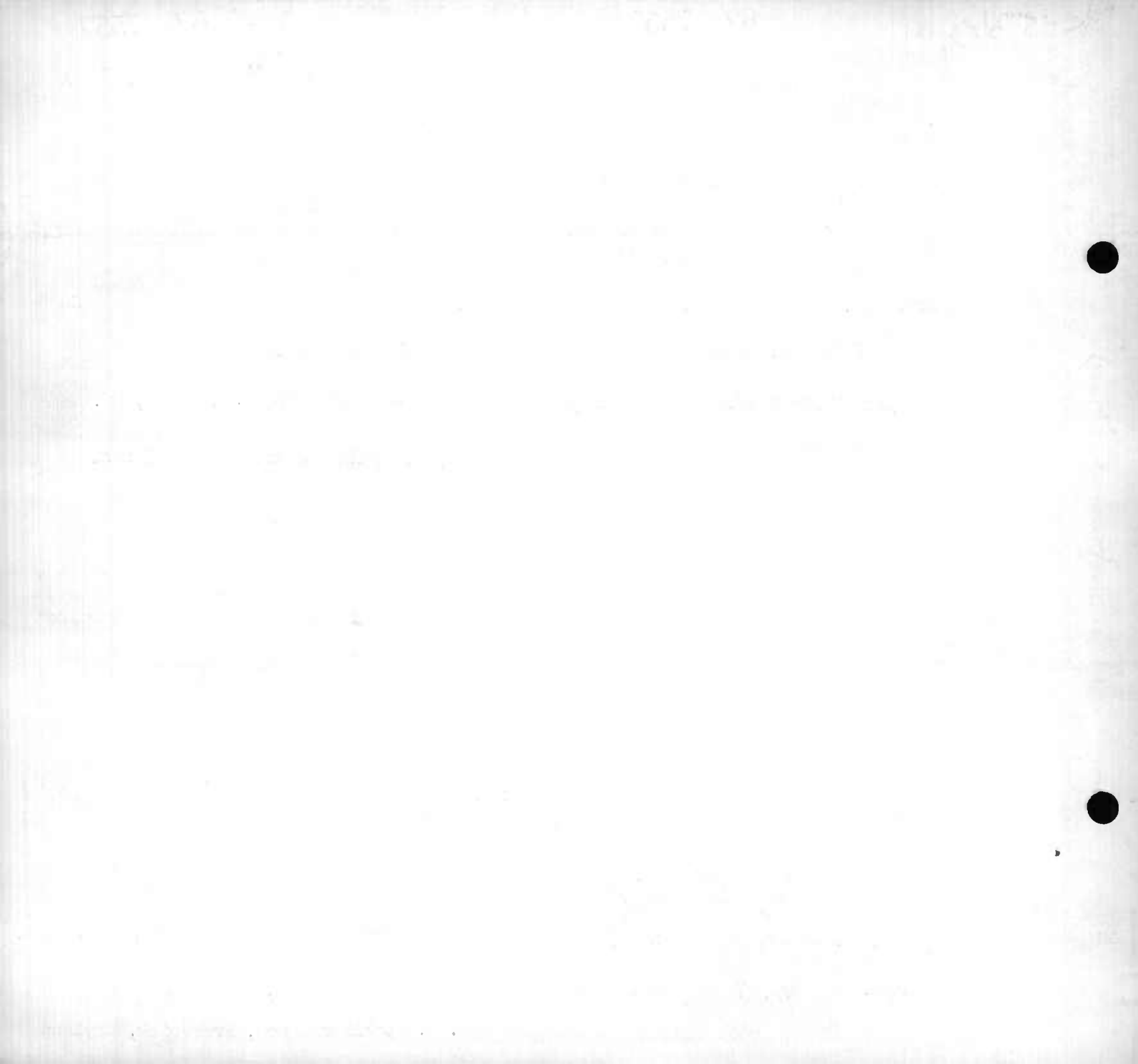
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7556	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 7556 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) ISAAC NORRIS			2. DATE AND HOUR OF DEATH 8/6/67 1 46 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIV. of MARYLAND Hosp. </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE MARYLAND </div> <div> B. COUNTY 13-01 </div> </div>		
5. SEX M 6. RACE N 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH 7-4-04 9. AGE (In years, lost, birthday) 63 68		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. 1538 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Colonic CARCINOMA WITH METASTASES			CAUSE OF DEATH (A) DUE TO To Ribs, Lung, Liver		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/3/67 19 to 8/6/67 19, that (I) (we) last saw the deceased alive on 8/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary Norman Wilner M.D.				23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type) GARY NORMAN WILNER				23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITALS.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME of CEMETERY or CREMATORY Church Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967			
25B. NAME OF REGISTRAR Robert E. Fairburn		25C. FUNERAL DIRECTOR V. Brooks Ruggold ADDRESS 1463 N. Carey St			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

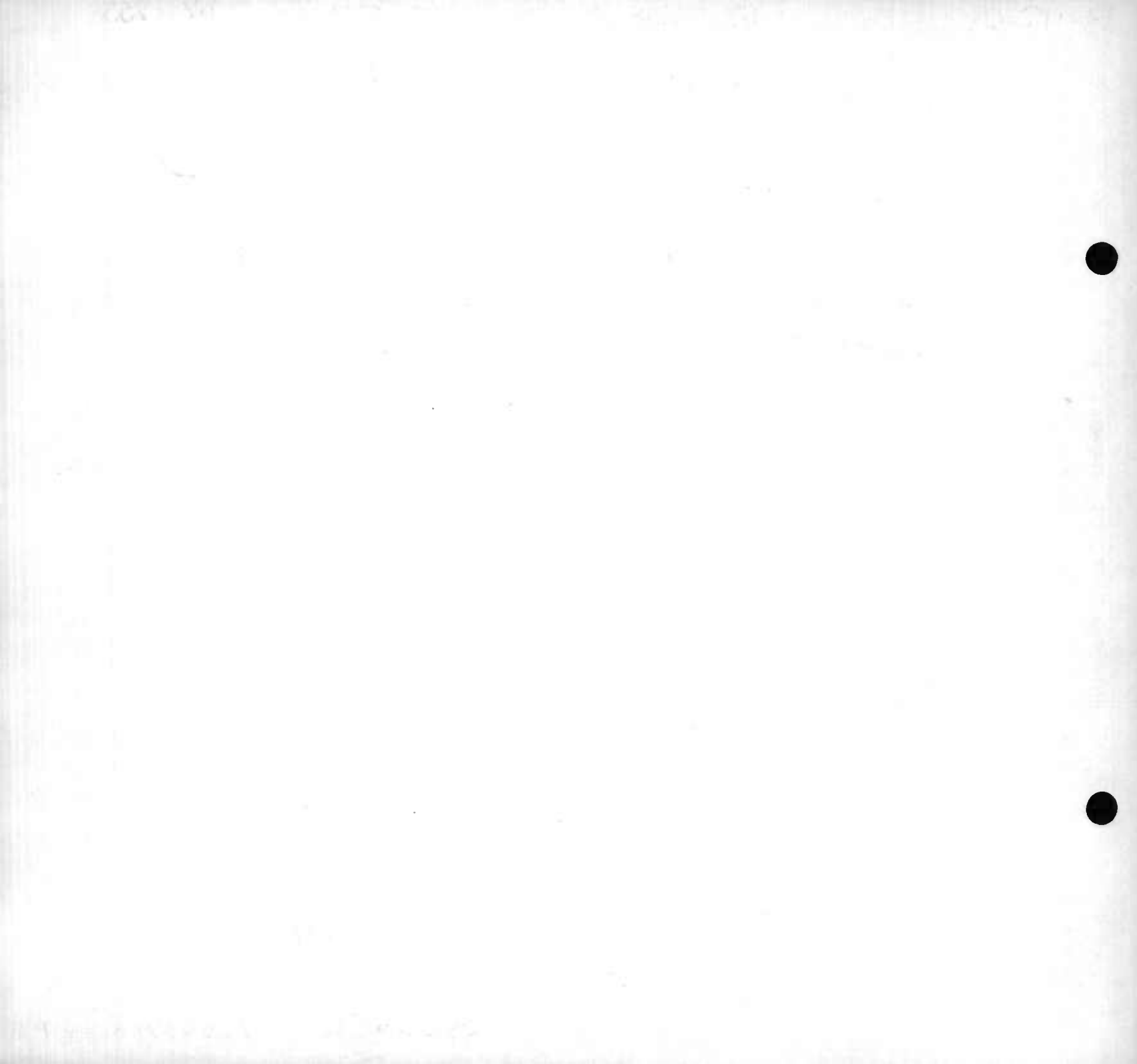
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7557	
BIRTH NO. 67 7557		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Austin Joseph Kennedy		2. DATE AND HOUR OF DEATH Aug. 4, 1967 8:15 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Frederick Co.			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Frederick 60-11			
		D. STREET ADDRESS (If rural, give location) 915 Cherokee Trail			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/27/37	9. AGE (In years last birthday) 30	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Adm. Sanitary Comm.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph B. Kennedy			14. MOTHER'S MAIDEN NAME Margaret Kidd		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes USAF 1956-1960		16. SOCIAL SECURITY NO. 215-34-2732		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. 204-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Acute lymphocytic leukemia		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary hemorrhage		Terminal	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 26 1967 to Aug. 4 1967 , that (I) (we) last saw the deceased alive on Aug. 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE Henry S. Crist M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/4/67	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surgeon (R)		23D. ADDRESS M.D. US Public Health Service Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/67		24C. NAME of CEMETERY or CREMATORY Mount Olivet Cemetery	
				24D. LOCATION (City, town, or county) (State) Frederick, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Fairbairn		25C. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

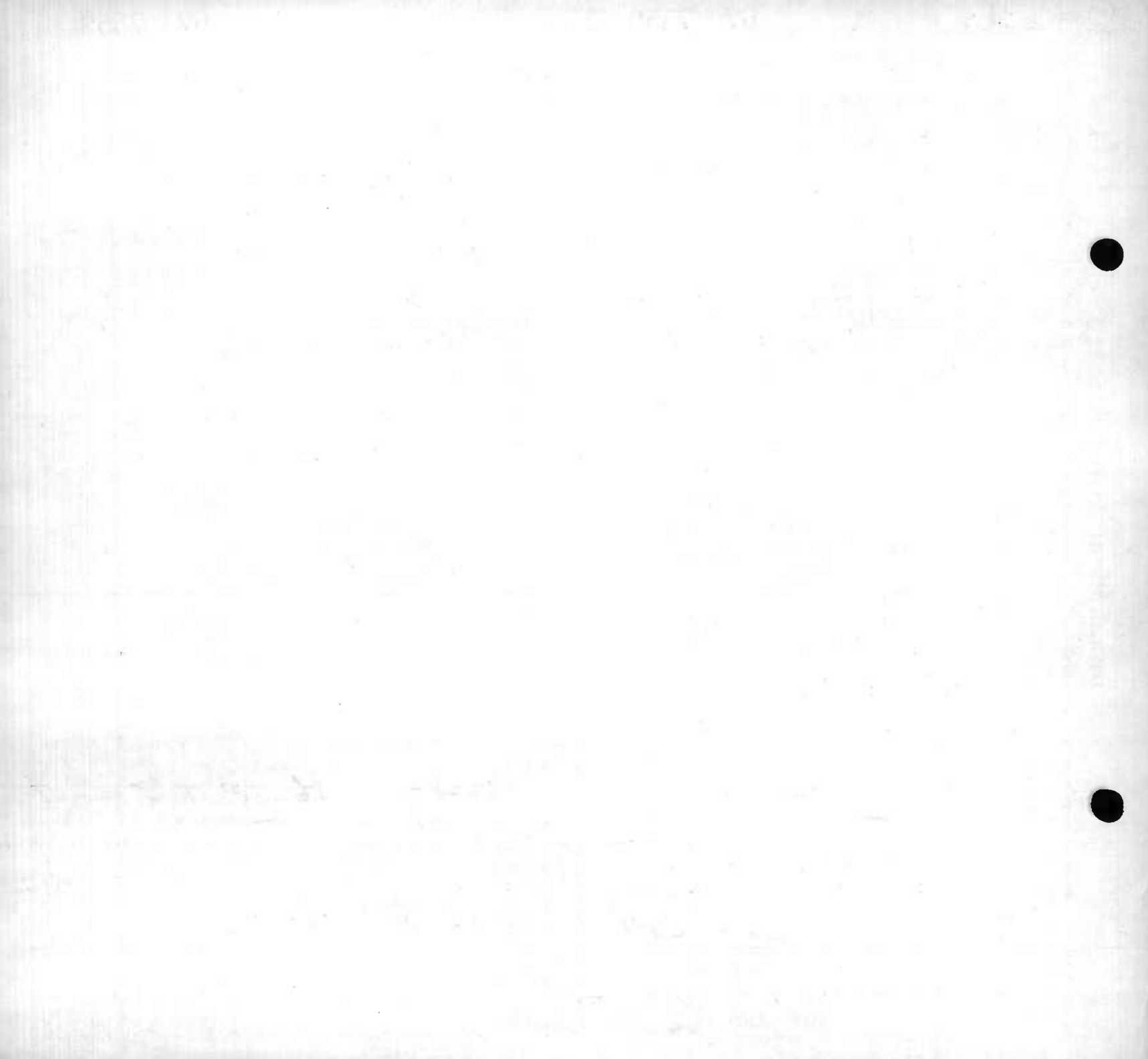
BIRTH NO. 67 7558				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7558	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Block Seline</i>				2. DATE AND HOUR OF DEATH <i>8-6-67 9:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>53-00</i> <i>Baltimore county (CATONSVILLE)</i> D. STREET ADDRESS (If rural, give location) <i>330 StoneWall Rd. 21228</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2-6-73</i>	9. AGE (In years last birthday) <i>94</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>on Home</i>		11. BIRTHPLACE (State or foreign country) <i>PITTS, PA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Louise Schwab</i>				14. MOTHER'S MAIDEN NAME <i>Florine</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>053383018</i>		17. INFORMANT <i>MARK BLOCK</i>		ADDRESS <i>SAME</i>	
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Arteriosclerotic Heart Disease</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
				(B) <i>Pulmonary infarcts, bilat.</i> DUE TO		<i>2 weeks</i>	
				(C) <i>Duodenal ulcer, healed</i>		<i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>—</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>8-2</i> 19 <i>67</i> to <i>8-6</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Aug. 6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Byung Kap Kang</i> M.D., Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <i>Aug. 6, 1967.</i>	
23C. PHYSICIAN'S NAME (Type) <i>BYUNG KAP KANG</i> M.D.				23D. ADDRESS <i>BON SECOURS HOSPITAL 2025 W FAYETTE ST, BALTO, MD 21223</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal & Burial</i>		24B. DATE <i>8/9/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Waltwyck Cemetery, Kingston, New York</i>		24D. LOCATION (City, town, or county) (State) <i>—</i>	
25A. DATE RECEIVED <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Md</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SYLVANUS S. LEWIS & SON, GARRISON, Md</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 7559	
BIRTH NO. 67 7559		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Jerome K Undutch</u>		2. DATE AND HOUR OF DEATH <u>August 5, 1967 10:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1806 Byrd Street Baltimore, Md. 21230</u>		A. STATE <u>Md.</u> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location) <u>1806 Byrd St.</u>		24-04	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>9-18-02</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipfitter - Rev. Port Authority</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Undutch</u>		14. MOTHER'S MAIDEN NAME <u>Sally Sherlock</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-5559</u>		17. INFORMANT <u>MRS. Mary Undutch (wife)</u>	
18. ADDRESS <u>Same</u>		19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cirrhosis of Liver</u>		(A) DUE TO		<u>10 yrs.</u>	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>-</u>		22. I certify that (I) (this hospital) attended the deceased from <u>5-28-1956</u> to <u>August 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>C. C. CHIU</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>August 5, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. C. CHIU</u>		23D. ADDRESS <u>1 E. Randall St. Baltimore (30) Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/9/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Crem</u>	
24D. LOCATION (City, town, or county) (State) <u>A. A. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Tankyura</u>	
25C. FUNERAL DIRECTOR <u>McCall's Funeral Home</u>		ADDRESS <u>130 E. Fort Ave</u>		<u>21230</u>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		67 7560		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7560	
1. NAME OF DECEASED (Type or Print) Nancy F. Ellis				2. DATE AND HOUR OF DEATH 1 AUGUST 5, 1967 9 20 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY BALTIMORE Co.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) CARNEY 53-00			
				D. STREET ADDRESS (If rural, give location) 9403 FLAGSTONE DR			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH SEP 27 1926	9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph Ellis Same	
18. 465X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY HYPERTENSION INTERVAL BETWEEN ONSET AND DEATH 3 YRS				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RECURRENT PULM. EMBOLISM 3 YRS				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 7-26-67 19 to 8-5-67 19, that (we) last saw the deceased alive on 8-5-67 19, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
23A. SIGNATURE Gary Norman Wilner MD.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-5-67	
23C. PHYSICIAN'S NAME (Type) GARY NORMAN WILNER				23D. ADDRESS UNIVERSITY OF MD. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/67		24C. NAME OF CEMETERY OR CREMATORY Shesheguim Cemetery Shesheguim		24D. LOCATION (City, town, or county) (State) Penn	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR C. F. EVANS & Son		ADDRESS 8802 Hartford Rd	

Handwritten text, possibly a letter or document, with some legible words like "Honor" and "of".

Handwritten text, possibly a signature or name, including the word "James".

Handwritten text, possibly a date or reference, including the words "January 1892".

Handwritten text, possibly a date or reference, including the words "Jan 1892".

Handwritten text, possibly a signature or name, including the words "C. F. Evans".

Handwritten text, possibly a signature or name, including the words "C. F. Evans".

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <i>67 7561</i>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>67 7561</i>	
1. NAME OF DECEASED (Type or Print) <i>Lindy A. Woods</i>		2. DATE AND HOUR OF DEATH <i>August 4 1967 9:15 AM</i>			
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>ANNE ARUNDEL Co.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ANNEAPOLIS 52-10</i>			
D. STREET ADDRESS (If rural, give location) <i>145 PRINCE GEORGE ST.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>N/A</i>	8. DATE OF BIRTH <i>7/18/67</i>	9. AGE (In years lost birthday) <i>27</i>	If Under 1 Yr. Months: <i>27</i> Days: <i>27</i> Hours: <i>27</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N/A</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>		11. BIRTHPLACE (State or foreign country) <i>ANNE ARUNDEL County</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John M. Woods</i>		14. MOTHER'S MAIDEN NAME <i>JEAN BROWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT <i>JOHN M. Woods # 4</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Staphylococcal Septicemia + Empyema</i>		CAUSE OF DEATH <i>Staphylococcal Septicemia + Empyema</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Exanthematosis</i>		(B) DUE TO <i>Exanthematosis</i>		(C) <i>Possible Cong. Heart Disease</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Exchange Transfusions, Mongolism - POSSIBLE, ANURIA, Fracture of Radius & Ulna, GRAND Mal Seizure</i>		19A. DATE OF OPERATION <i>July 31, 1967</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>thoracotomy Tube placed</i>	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/28 1967</i> to <i>8/4 1967</i> , that (I) (we) lost saw the deceased alive on <i>8/4 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James B. Brayton</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/4/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JAMES B. BRAYTON</i>		23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8-6-67</i>		24C. NAME of CEMETERY or CREMATORY <i>CEDAR Bluff</i>	
24D. LOCATION (City, town, or county) (State) <i>ANNEAPOLIS MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	
25C. FUNERAL DIRECTOR <i>John M. Tyn + Son</i>		ADDRESS <i>Annapolis, Md.</i>			

General A. C. ...

St. Johns Hospital

W M

M M

John M. Woods

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Epithelial ...

... of the ...

possible cond. Heart ...

... of ...

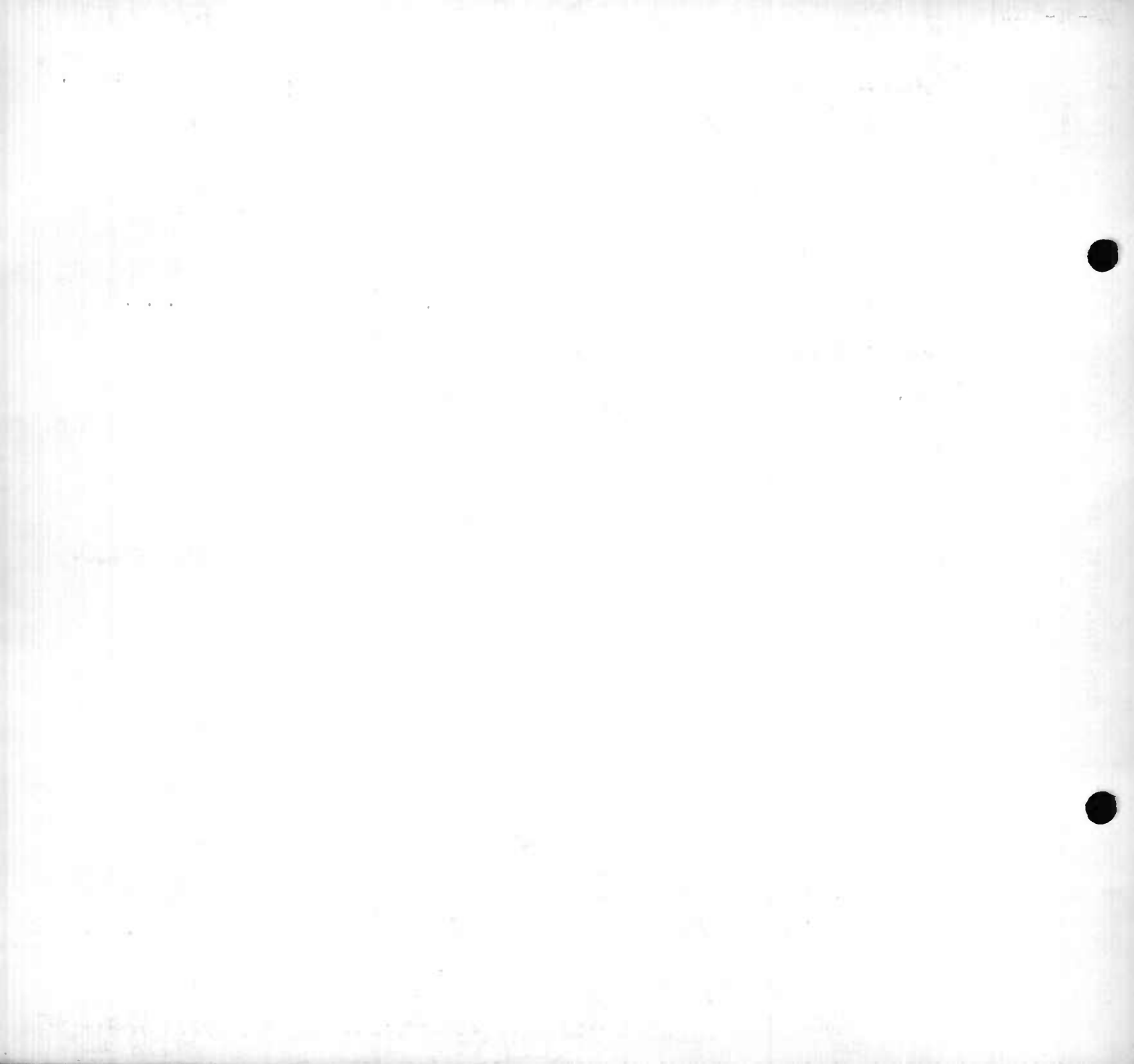
... of ...

... of ...

James B. ...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

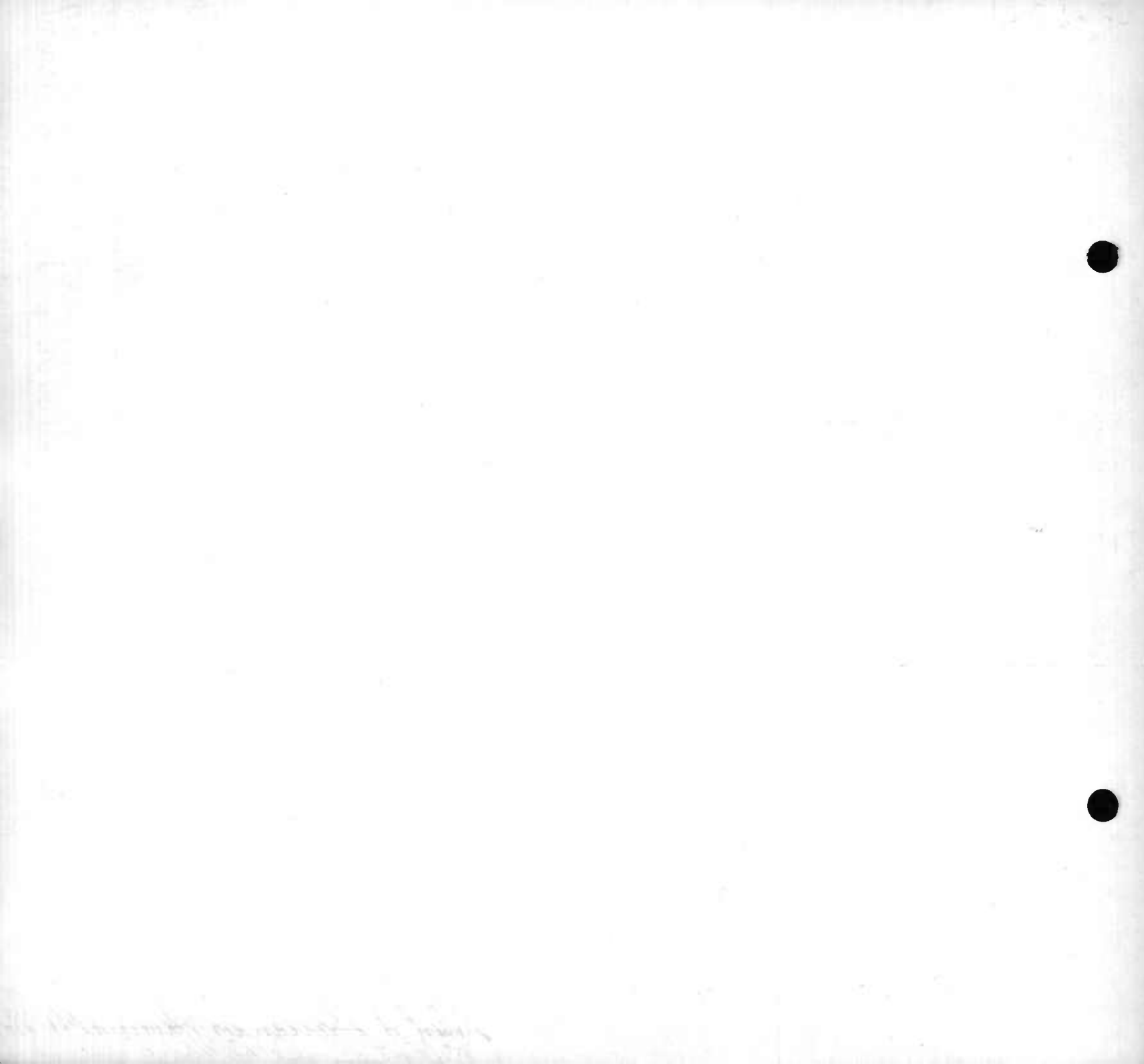
BIRTH NO. H-200				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7562	
M.E. CASE NO.				BIRTH NO. 67 7562			
1. NAME OF DECEASED (Type or Print) ALICE Louise Houck				2. DATE AND HOUR OF DEATH August 3, 1967 5:20 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore City Hospitals FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 31				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
5. SEX Female				6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY at home		8. DATE OF BIRTH 3-23-21	
13. FATHER'S NAME Walter Clarey				14. MOTHER'S MAIDEN NAME UNKNOWN		9. AGE (In years last birthday) 46	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO.		17. INFORMANT BCH: RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 175.0 I Respiratory arrest CAUSE OF DEATH (A) Respiratory arrest DUE TO (B) ? pulmonary edema DUE TO (C) Ovarian Adenocarcinoma, metastatic 5 mms. INTERVAL BETWEEN ONSET AND DEATH				19. DATE OF OPERATION		20. AUTOPSY? (Yes or No) NO	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 2 19 67 to August 3 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 3 19 67 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				23A. SIGNATURE Joel Thurm M.D.		23B. DATE SIGNED 8/3/67	
23C. PHYSICIAN'S NAME (Type or Print) DR. JOEL THURM JOEL THURM				23D. ADDRESS BALTO. CITY HOSP M.D. BALTO. MD. 21224		23E. DATE OF DEATH 8/3/67	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/7/67		24C. NAME OF CEMETERY or CREMATORY Int. Olivet Cemetery	
24D. LOCATION Balto. Md.				24E. DATE REC'D BY HEALTH DEPT. AUG 8 1967		24F. NAME OF REGISTRAR Robert E. Farley	
24G. DATE REC'D BY HEALTH DEPT. AUG 8 1967				24H. NAME OF REGISTRAR Robert E. Farley		24I. FUNERAL DIRECTOR John J. Brown, Jr., Inc.	
24J. ADDRESS 901 Hollins St. Balto. Md.				24K. ADDRESS 901 Hollins St. Balto. Md.		24L. ADDRESS 901 Hollins St. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

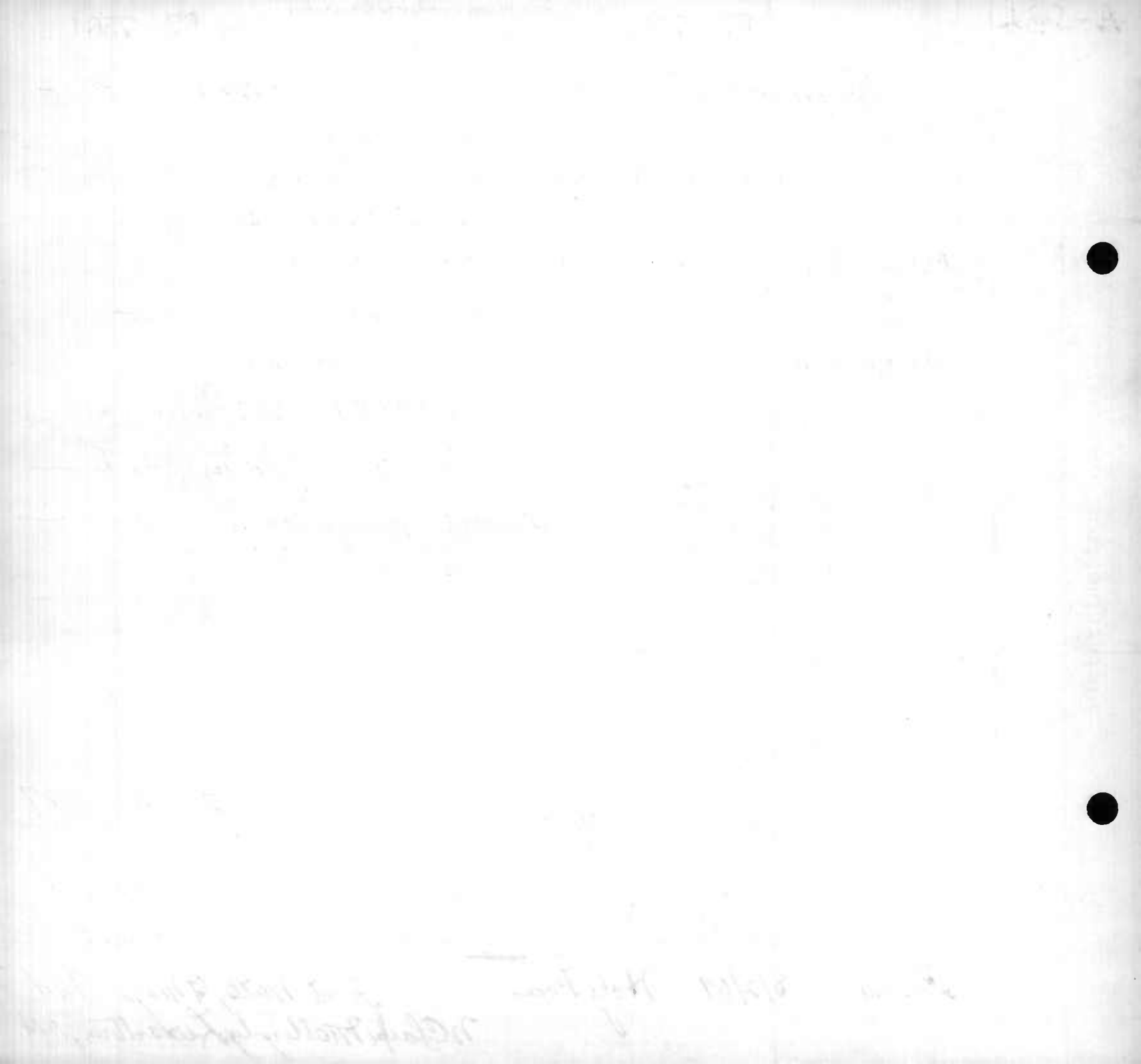
BIRTH NO. 67 7563		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 67 7563	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Sarah Gibbons</i>			2. DATE AND HOUR OF DEATH <i>8-3-1967 5:30 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>43 South Baltimore General Hosp.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-05</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i> D. STREET ADDRESS (If rural, give location) <i>1019 Church St.</i>		
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-8-1890</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Phillip Crooks</i>			14. MOTHER'S MAIDEN NAME <i>Isabella Pentland</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>ELMER L. GIBBONS</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Septecemia -</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week -</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Post Hemicolectomy</i> <i>Bleeding Diverticulitis</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>7-17-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding Diverticulitis</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>7-11-1967</i> to <i>8-3-1967</i> , that (we) last saw the deceased alive on <i>8-3-1967</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose V. Iglesias</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-4-67</i>
23C. PHYSICIAN'S NAME (Type) <i>Jose V. Iglesias</i>			23D. ADDRESS <i>1213 Light Street Baltimore 21230 Md.</i>		
24A. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL REMOVAL</i>		24B. DATE <i>8/7/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Fairview Lawn Cem.</i>	
24D. LOCATION (City, town, or county) <i>ONANCOCK, VIRGINIA</i>		(State) <i>ONANCOCK, VIRGINIA</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Garman</i>		25C. FUNERAL DIRECTOR'S ADDRESS <i>Robert E. Garman, Augusta, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

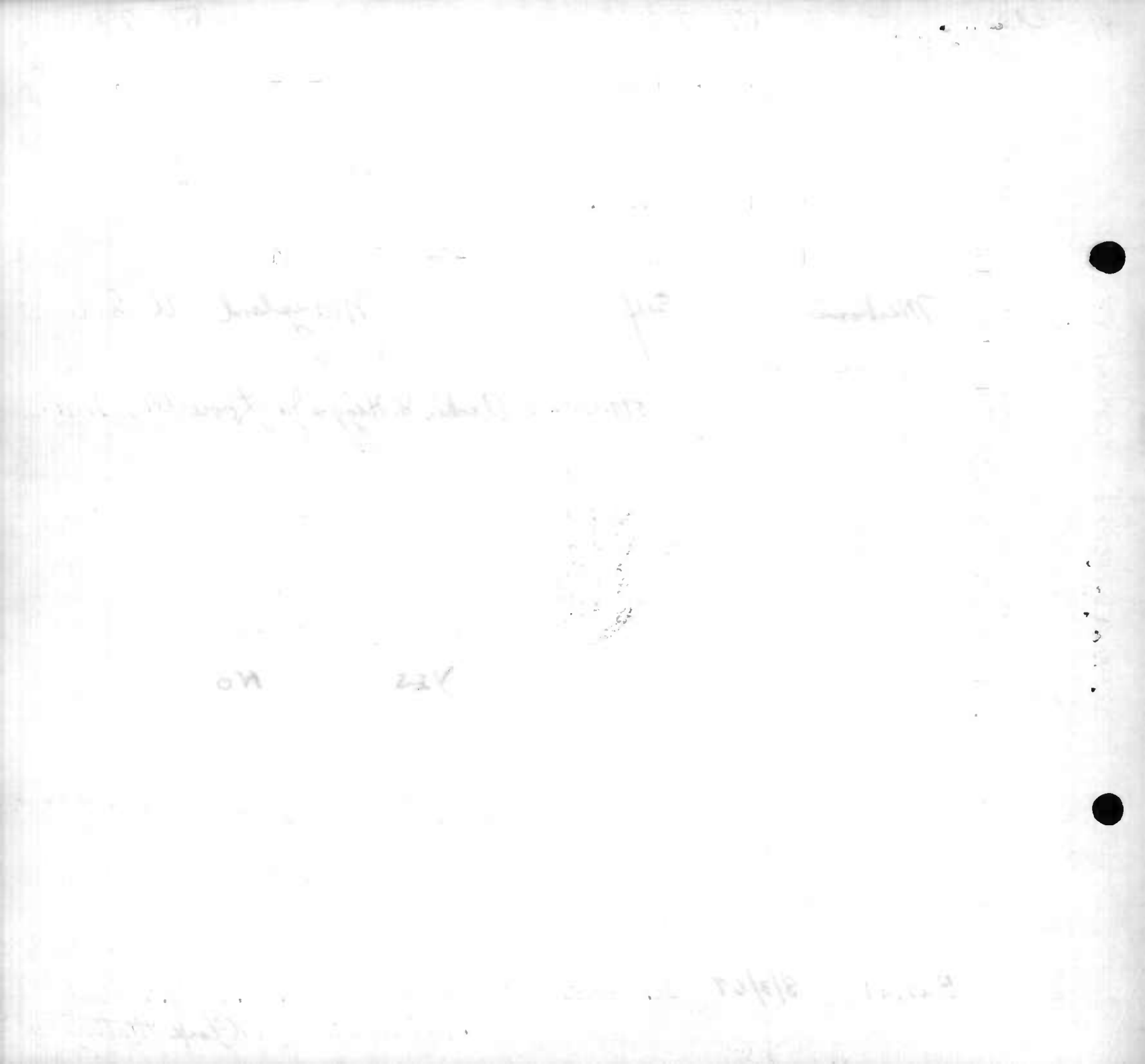
BIRTH NO. 67 7564		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7564	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Ignatius Anderson</i>		2. DATE AND HOUR OF DEATH <i>7-30-1967 7:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>St. Mary's Co.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Lexington PARK 68400</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nurs. Home.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>11 Lincoln AVE.</i>	
5. SEX <i>Male</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>8-11-82</i>	9. AGE (in years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>Olivia Granda</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart # 709 607 Penna AVE.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>260X1</i>		CAUSE OF DEATH (A) DUE TO <i>Diseases mellitus</i> (B) DUE TO <i>Septic. splenitis</i> (C) DUE TO <i>Ch 7.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/2</i> 19 <i>65</i> to <i>7/30</i> 19 <i>67</i> . that (I) (we) lost saw the deceased alive on <i>7/30</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E E Holt</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/30/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E E Holt</i>		23D. ADDRESS M.D. <i>3715 Liberty Street</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/2/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Face</i>	
24D. LOCATION (City, town, or county) (State) <i>Great Mills St Marys Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Sperry</i>	
25C. FUNERAL DIRECTOR <i>McClure Mattingly Leonardtown, Md.</i>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are released for burial or cremation. If the body is released for burial or cremation, the remains are to be released to the funeral home or to the family for burial or cremation. If the body is released for burial or cremation, the remains are to be released to the funeral home or to the family for burial or cremation.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		67 7565 ARCHIE S. HIGGS		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7565	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		2. DATE AND HOUR OF DEATH 7-30-67 10,20 P.M.			
33 JOHNS HOPKINS HOSPITAL.		MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) COMPTON		D. STREET ADDRESS (If rural, give location) 68-20			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED SEP	8. DATE OF BIRTH 1-6-1916	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MITCHELL HIGGS		14. MOTHER'S MAIDEN NAME JULIA BUSH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 579-03-2410		16. SOCIAL SECURITY NO. 579-03-2410	
17. INFORMANT Archie S. Higgs Jr		ADDRESS Lorville, Md.		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac & respiratory arrest		INTERVAL BETWEEN ONSET AND DEATH 35 min.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of esophagus		20. CAUSE OF DEATH Anaphylactic reaction to Penicillin		21. INTERVAL BETWEEN ONSET AND DEATH 39 min.			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of esophagus		23. INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hospital			
21D. TIME OF INJURY (APPROX.) 7-30-67 9:40 P.M.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Reaction to I.V. Penicillin			
22. I certify that (I) (this hospital) attended the deceased from 7/8 19 67 to 7/30 19 67, that (I) (we) last saw the deceased alive on 7/30 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Denis H. Tyras				23B. DATE SIGNED 7/30/67			
23C. PHYSICIAN'S NAME (Type) DENIS H. TYRAS				23D. ADDRESS JOHNS HOPKINS HOSPITAL BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/67		24C. NAME OF CEMETERY or CREMATORY St. Francis Xavier Cemetery		24D. LOCATION (City, town, or county) (State) Compton, St. Mary's, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR W. Clarke Mattingley		25D. ADDRESS W. Clarke Mattingley	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 7566		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7566	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>SCOTT E. SCOTT</i>		2. DATE AND HOUR OF DEATH <i>Aug. 6, 1967 9 25 A M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>MD.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>SALT. 21211 12-07</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>MARYLAND GEN. HOSP</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>317 WYMAN PK. Dr.</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>S</i>	8. DATE OF BIRTH <i>11/06/23</i>	9. AGE (In years last birthday) <i>43</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>PENNA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JOHN RHOADS</i>		14. MOTHER'S MAIDEN NAME <i>CATHERINE MOYER</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>DAUGHTER</i>	
18. <i>199.2 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Abdominal Carcinoma</i>		<i>6 mo.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>ASCVD</i>		(C) <i>10 y.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/18</i> <i>19 67</i> to <i>8/6</i> <i>19 67</i> , that (I) (we) last saw the deceased alive on <i>8/6</i> <i>19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. Moravec, MD</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/6/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. MORAVEC</i>		M.D. 23D. ADDRESS <i>MARYLAND GEN. HOSP.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/9/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Taylor Ave, Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>	
25C. FUNERAL DIRECTOR <i>Austin E. Donovan</i>		ADDRESS <i>3818 Roland Ave</i>			

10/1/1917

Mr. J. H. Jones
2
The
Tom Jones
by

Mr. J. H. Jones
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Mr. J. H. Jones
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Tom Jones
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67. 7567 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67. 7567

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) CLARENCE E. GAITHER

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967 12:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

40 St. Agnes Hospital

Baltimore

D. STREET ADDRESS (If rural, give location)

122 Winters Lane

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single

8. DATE OF BIRTH

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Male

Negro

Sept 28, 1938

28

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

Laborer

Construction

Baltimore, Md

U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

John Evan Gaither

Margaret Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

No

217-34-4662

Mr. John E. Gaither 122 Winters Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Massive internal bleeding
DUE TO gunshot wound of chest involving
the right lung.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

August 5, '67 12:30 A.M.

WHILE AT
WORK

NOT WHILE
AT WORK

Subj. shot while attempt-
ing to break up fight between 2 other
people

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

8/9/67

Western Star Cemetery

Catonsville

Balto Co., Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 8 1967

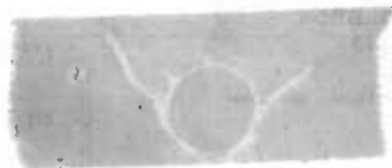
Robert E. Spitz

Herbert E. Nutter 3035 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7568		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7568	
1. NAME OF DECEASED (Type or Print) Fannie Ellen Johnson			2. DATE AND HOUR OF DEATH 8/2/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2810 Windsor Avenue (Home)			A. STATE Maryland B. COUNTY Baltimore		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			D. STREET ADDRESS (If rural, give location) 2810 Windsor Ave.		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/1/1875	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Westmorland CO. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME David Crockett		
14. MOTHER'S MAIDEN NAME Malinda Parlor			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 216-54-2686T			17. INFORMANT ADDRESS Mr Ernest Johnson 1516 Appleton ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchitis Pneumonia			CAUSE OF DEATH (A) DUE TO Bronchitis Pneumonia		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Thrombosis			(B) DUE TO Cerebral Thrombosis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis			(C) DUE TO Arteriosclerosis		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 28 1967 to Aug 3 1967 , that (I) (we) last saw the deceased alive on Aug 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. K. Adams			23B. DATE SIGNED Aug 3 - 1967		
23C. PHYSICIAN'S NAME (Type) F. K. ADAMS			23D. ADDRESS 1222 N. CAROLINE ST. BALTO. MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore CO. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7569					CERTIFICATE OF DEATH				
BIRTH NO.					Registered No. 67 7569				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) DAISEY I. DUNCAN				
2. DATE AND HOUR OF DEATH 4 AUG. 1967 7:30 A.M.					3. PLACE OF DEATH IN BALTIMORE, MARYLAND				
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Talbot Baltimore					5. CITY OR TOWN (If outside city limits, write RURAL and give township) Ridgemoor Baltimore				
6. STREET ADDRESS (If rural, give location) 5107 Wesley Ave.					7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5107 Wesley Ave. Baltimore, Md.				
8. SEX Female		9. RACE white		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed		11. DATE OF BIRTH 10/22/1876		12. AGE (In years last birthday) 90	
13. Under 1 Yr. Months		14. Under 24 Hrs. Days		15. Under 24 Hrs. Hours		16. Under 24 Hrs. Min.			
17A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework					17B. KIND OF BUSINESS OR INDUSTRY				
18. BIRTHPLACE (State or foreign country) Maryland					19. CITIZEN OF WHAT COUNTRY? USA				
20. FATHER'S NAME C. James Howeth					21. MOTHER'S MAIDEN NAME Emma Covington				
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					23. SOCIAL SECURITY NO.				
24. INFORMANT Mrs. Ethel Nolan, Baltimore, Md.					25. ADDRESS 5107 Wesley Ave.				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					INTERVAL BETWEEN ONSET AND DEATH				
(A) PERFORATED GALL BLADDER					20 HRS.				
(B) CHRONIC CHOLECYSTITIS					40 YRS.				
(C)									
II HEART DISEASE									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					HYPERTENSIVE ARTERIOSCLEROTIC				
19A. DATE OF OPERATION DEC 11, 1958					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from DEC. 11, 1958 to AUG. 4, 1967 , that (I) (was) last saw the deceased alive on AUG. 3, 1967 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.									
23A. SIGNATURE Marvin Goldstein					23B. DATE SIGNED 4 AUG. 1967				
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN					23D. ADDRESS 6001 PARK HEIGHTS AVE. BALTO. MD.				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/7/1967				
24C. NAME OF CEMETERY or CREMATORY Methodist					24D. LOCATION (City, town, or county) (State) Tilghman, Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967					25B. NAME OF REGISTRAR Robert E. Farley				
25C. FUNERAL DIRECTOR MURPHY E. NEWMAN & SON, Easton, Md.					25D. ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7570	
BIRTH NO. 67 7570		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CURRY, Myrtle		2. DATE AND HOUR OF DEATH Aug. 6, 1967 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION North CHARLES GENERAL HOSP 519 N. CHARLES STREET BALTIMORE, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 7-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 519 N. Kenwood Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH JULY 13-1898	9. AGE (In years last birthday) 69 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired seamstress		10B. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? MD.		13. FATHER'S NAME Wm. H. WOLFE		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-014828		17. INFORMANT ADDRESS Carrie Layne (Sister)	
18. 296X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) GASTROINTESTINAL Hemorrhage DUE TO (B) THROMBOCYTOPENIA DUE TO (C) Selvin Posen, MD		INTERVAL BETWEEN ONSET AND DEATH 5th	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 5 1967 to Aug. 6 1967 , that (I) (we) last saw the deceased alive on Aug. 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Lewis Kolodny				23B. DATE SIGNED Aug. 6, 1967	
23C. PHYSICIAN'S NAME (Type) A. Lewis Kolodny		23D. ADDRESS M.D. 1825 EASTERN Blvd. Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/67		24C. NAME of CEMETERY or CREMATORY LODON PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967			
25B. NAME OF REGISTRAR Robert E. Feldman		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME-WDBELTIR			

F W
FEDERAL STREET
BALTIMORE, MD
C/O J. K. Kennedy Co.
BALTIMORE
FEDERAL STREET
BALTIMORE, MD
C/O J. K. Kennedy Co.
BALTIMORE

for
214-14448 (inter)

from
from

A. Lewis Kolodny
1632 Eastern Blvd, 2nd
X
at
Conf. 2
Conf. 2
at
X
1632 Eastern Blvd, 2nd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

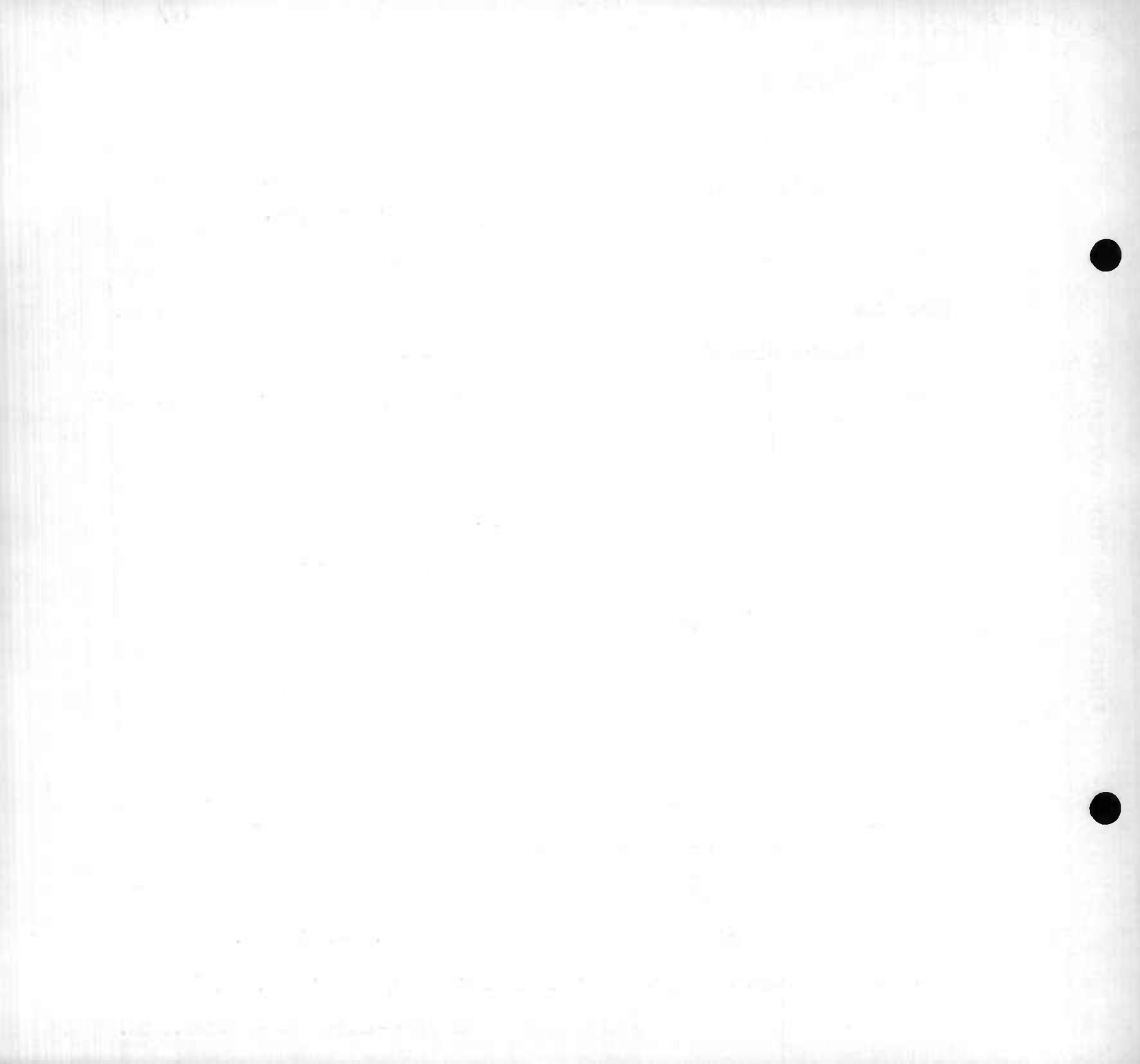
BIRTH NO. 67 7571				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7571	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Alberta B. Schlimme</i>				2. DATE AND HOUR OF DEATH <i>6 August 1967 7 28 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) <i>South Baltimore General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore County</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 22, Maryland</i> D. STREET ADDRESS (If rural, give location) <i>109 Dundalk Avenue 53-00</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>AUG 19 1893</i>	9. AGE (in years last birthday) <i>73</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>
13. FATHER'S NAME <i>Richard Bradyhouse</i>			14. MOTHER'S MAIDEN NAME <i>Anna Nolte</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>24-40-2987 A</i>		17. INFORMANT <i>LEROY SCHLIMME</i>		ADDRESS <i>109 DUNDALK AVE</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>241X I</i> [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pulmonary embolus</i> <i>Cor pulmonale</i> <i>Chronic obstructive airway disease & bronchial asthma</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <i>19 hrs 30 min</i> <i>7 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John Albert Biglieri</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>August 6, 1967</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/9/67</i>		24C. NAME of CEMETERY or CREMATORY <i>BALTIMORE NATIONAL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS <i>ULLRICH FUNERAL HOME - 4210 BELAIR.</i>			

8/15/67 - Correction form from funeral director.

ABC

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

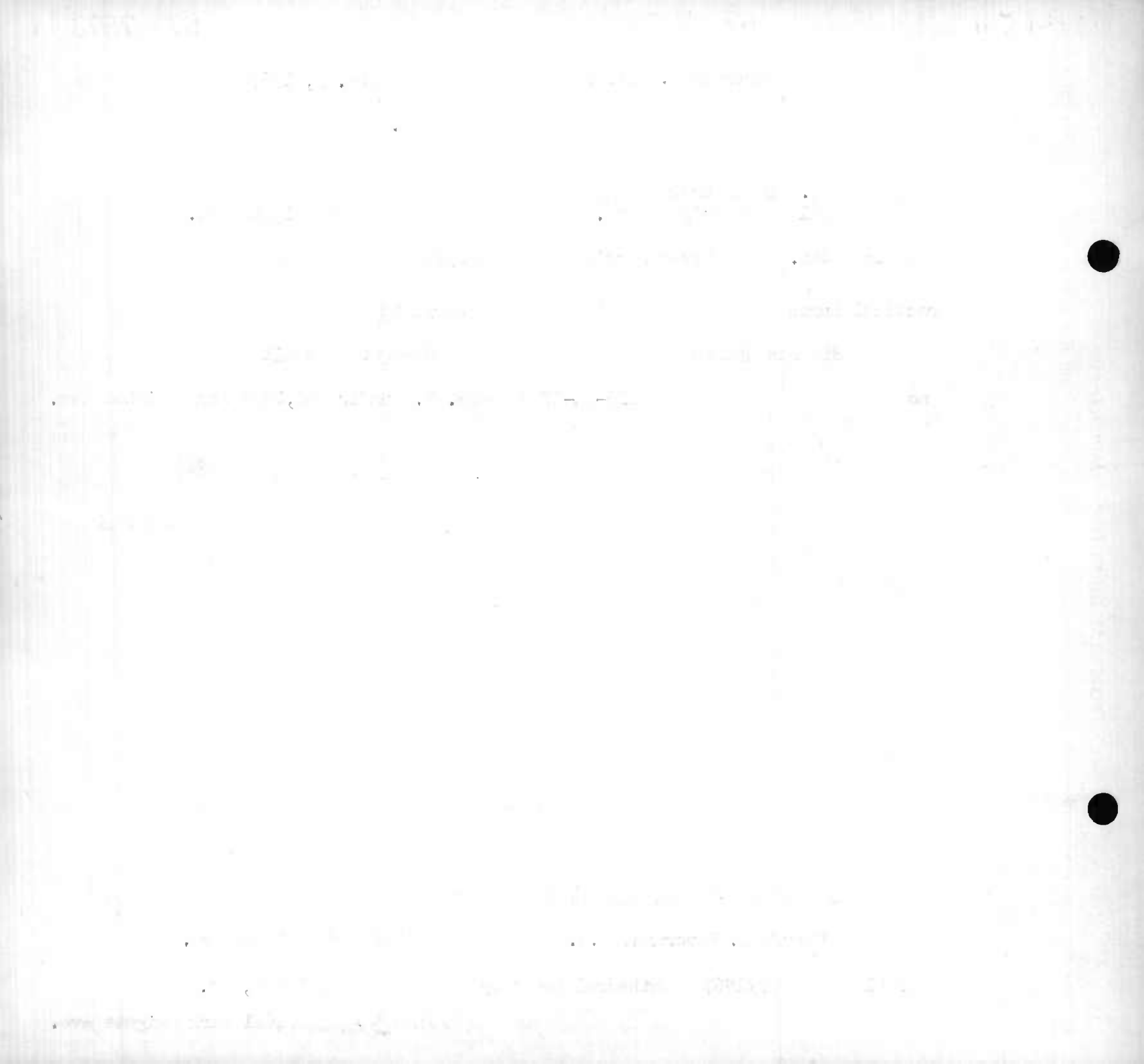
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. 67 7572		CERTIFICATE OF DEATH			
M.E. CASE NO. _____		1. NAME OF DECEASED (Type or Print) FANNIE GOLDEN WOLF		2. DATE AND HOUR OF DEATH 4 August 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3407 Claremont Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3407 Claremont Ave.			
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 21 May 1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Sindall		14. MOTHER'S MAIDEN NAME - - -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT John Wolf, 3407 Claremont Ave. 21224	
18. 7-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Coronary Thrombosis DUE TO (B) arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-23-67 19 to 8-4-67 19, that (I) (we) last saw the deceased alive on 8-2-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John Castantini 23C. PHYSICIAN'S NAME (Type) John Castantini				23B. DATE SIGNED 8-5-67	
23D. ADDRESS 234 S. Conkling St.					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-7-67		24C. NAME OF CEMETERY or CREMATORY First United Evan. Gemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Ullrich Funeral Home, Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 7573		REGISTERED NO. 67 7573	
1. NAME OF DECEASED (Type or Print) Gertrude E. Whalen				2. DATE AND HOUR OF DEATH Aug. 5, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Mt. Siani Nursing Home 4613 Park Heights Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-17 D. STREET ADDRESS (If rural, give location) 4807 Park Heights Ave.			
5. SEX Female	6. RACE Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 7/4/1883	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Stephen Whalen				14. MOTHER'S MAIDEN NAME Gerogania McNeil			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-32-8749		17. INFORMANT ADDRESS Mrs. M. Sunderland, 4807 Park Heights Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH 5915 INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 8/13/67 to Aug 5/67 that (I) (we) last saw the deceased alive on 8/13/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey S. Feuerman				23B. DATE SIGNED 8/5/67		23C. PHYSICIAN'S NAME (Type) Harvey S. Feuerman, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/1967		24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR G. Vernon Lemmon		25D. ADDRESS 4611 Park Heights Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7574	
BIRTH NO. 67 7574		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RIDGE, FREDERICK			
2. DATE AND HOUR OF DEATH 08-06-67 5:45PM M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 D. STREET ADDRESS (If rural, give location) 935 ELMRIDGE AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 07-05-93	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Sheet Metal Worker		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S					
13. FATHER'S NAME JOHN CARFIELD Ridge		14. MOTHER'S MAIDEN NAME LILA MYERS Lena Meyers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 28 9700A		17. INFORMANT CATON & WILKENS	
18. 199.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diffuse carcinoma tosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		18. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21F. HOW DID INJURY OCCUR?			
22. I certify that X (this hospital) attended the deceased from JULY 28, 19 67 to AUGUST 6, 19 67 , that X (we) last saw the deceased alive on AUGUST 6, 19 67 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXX view the body after death.					
23A. SIGNATURE Carolyn J. Pass		23B. DATE SIGNED 8-7-67		23C. PHYSICIAN'S NAME (Type) CAROLYN J. PASS, M.D.	
23D. ADDRESS ST. AGNES HOSPITAL, CATON & WILKENS					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/10/67	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) Baltimore	24E. ADDRESS MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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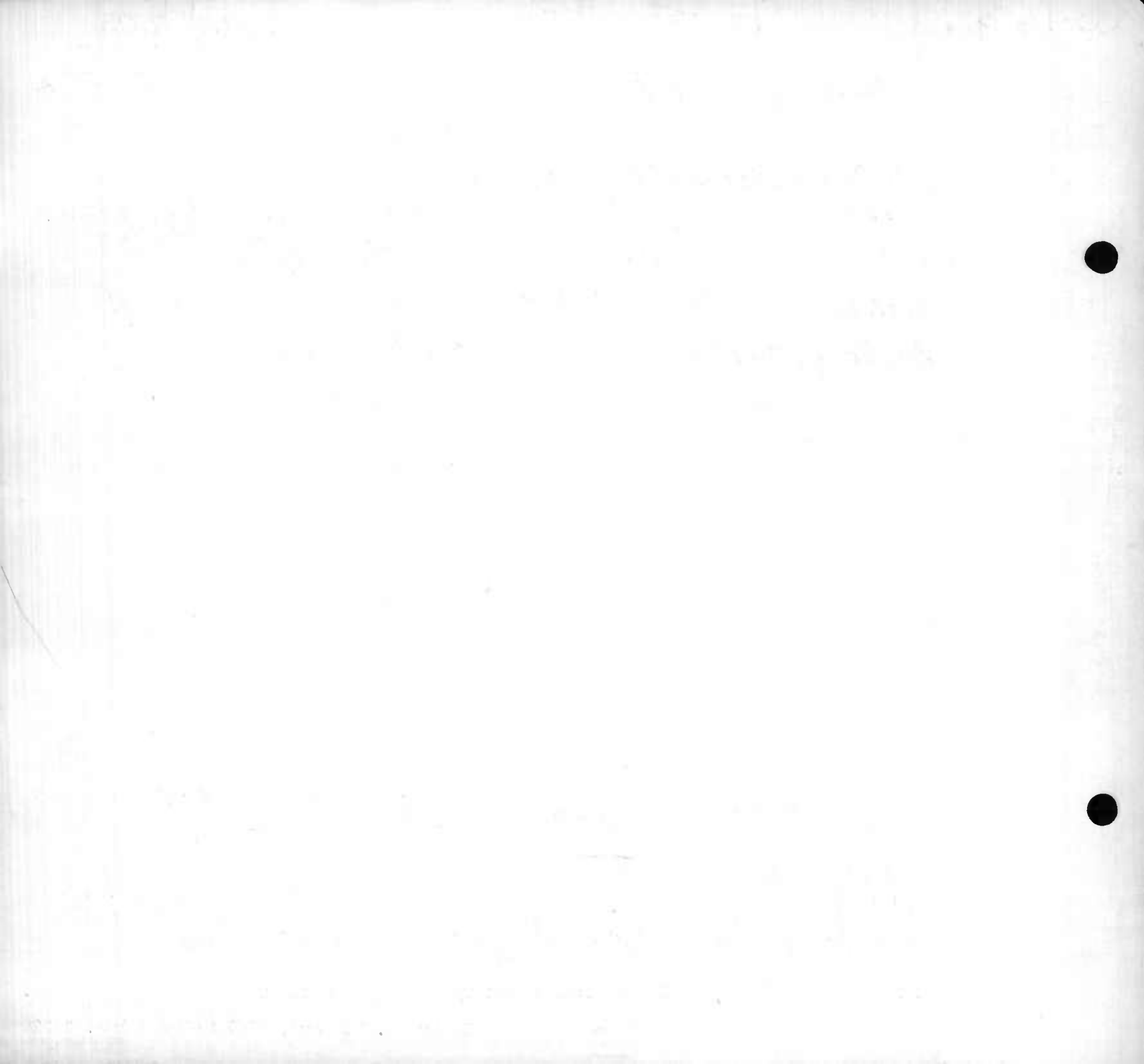
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 7575		CERTIFICATE OF DEATH		Registered No. 67 7575	
1. NAME OF DECEASED (Type or Print) <i>Webbert, Ethel A.</i>				2. DATE AND HOUR OF DEATH <i>8-7-67 3:50 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>North Charles General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-00</i> D. STREET ADDRESS (If rural, give location) <i>3008 Georgia Ave. 21227</i>					
5. SEX <i>Female</i>	6. RACE <i>Wh.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>11-20-1893</i>		9. AGE (In years lost birthday) <i>72 71</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Department Store</i>		11. BIRTHPLACE (State or foreign country) <i>Penn'a</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Bushong, Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Clark, Anna</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>chart</i>				ADDRESS
18. <i>20431</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Acute lymphatic leukemia</i>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>7-24</i> 19 <i>67</i> to <i>8-7</i> 19 <i>67</i> . that (I) (we) lost saw the deceased alive on <i>8-7</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>A. Schopf</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/7/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Schonfeld, Paul (Attending)</i>				23D. ADDRESS <i>2301 Annapolis Road</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>					



C-620

67 7576

BALTIMORE CITY HEALTH DEPARTMENT

67 7576

BIRTH NO. 60-37751		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 7576	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) PETER C.			2. DATE AND HOUR PRONOUNCED DEAD August 5, 1967 8:40 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 111xxxxl Osborne Avenue 21227		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 12/22/60	9. AGE (In years last birthday) 6	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Peter C. Craig Sr.			14. MOTHER'S MAIDEN NAME Angela J. Mc Guirk		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - -		17. INFORMANT ADDRESS Mrs. Angela J. Craig, 111 Osborne Ave. 21227	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cranio-Cerebral Injury ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rolling Road - 1330 ft. N. of Wilkins Ave	
21D. TIME OF INJURY (APPROX.) 8/5/67 6:40 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subj. passenger in car which was struck by another car.	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/7/67		23C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		24B. NAME OF REGISTRAR Robert E. Farkema		24C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	
23D. LOCATION Baltimore		23E. ADDRESS Md.		23F. ADDRESS 21229	

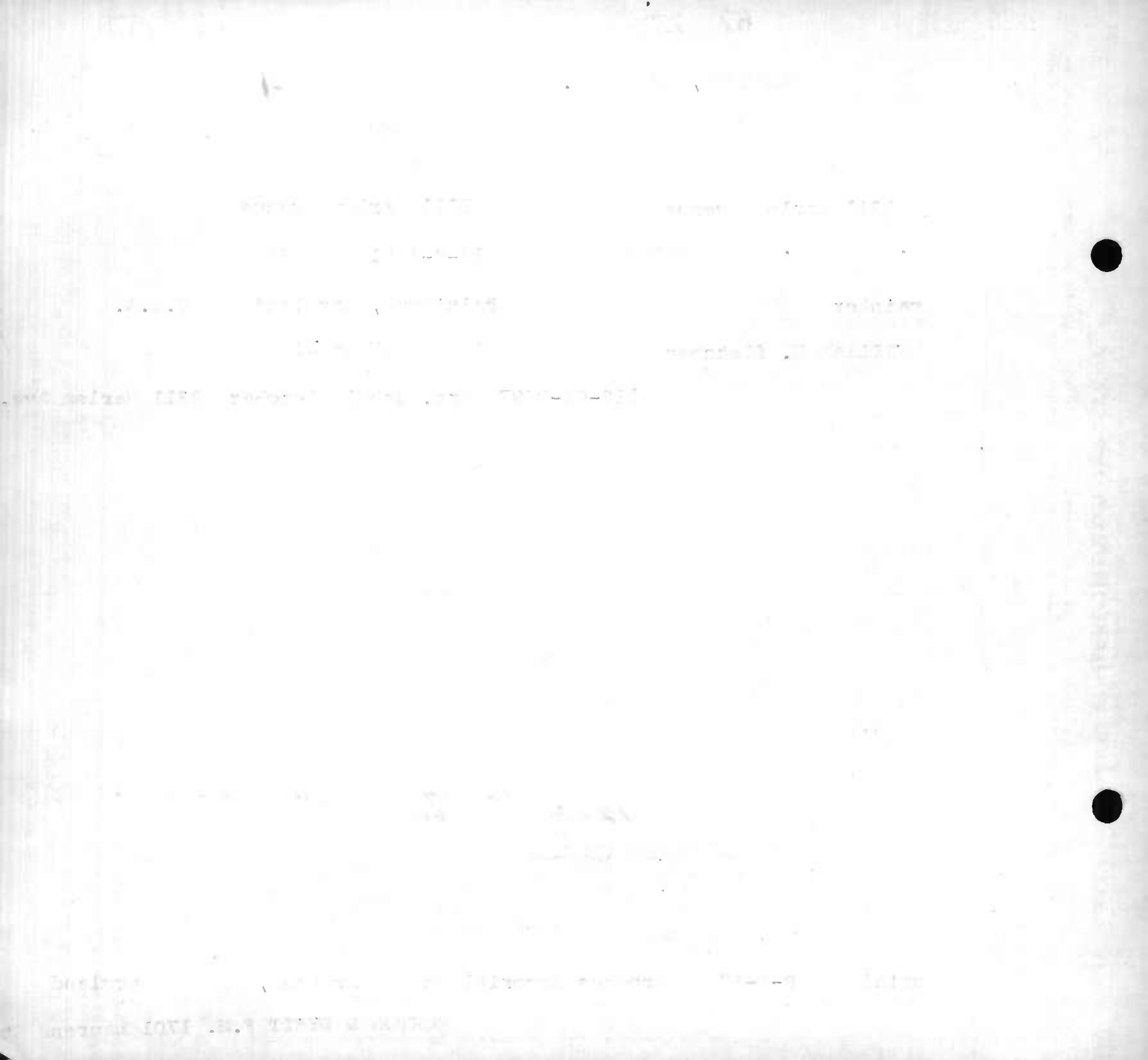
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				BIRTH NO. 67 7577		CERTIFICATE OF DEATH		Registered No. 67 7577		
1. NAME OF DECEASED (Type or Print) ALICE A. MITCHELL				2. DATE AND HOUR OF DEATH 8/5/67 9:10 PM						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 9.9.5. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE (LINTHICUM HEIGHTS) D. STREET ADDRESS (If rural, give location) 611 FOREST VIEW RD 52-00						
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/03/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Cunningham				14. MOTHER'S MAIDEN NAME Mary E. Swahn						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-36-8399		17. INFORMANT Mrs. Catherine A. Murphy, 611 Forest View Rd				ADDRESS Linthicum	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
				(A) UREMIA DUE TO				1 yr.		
				(B) RENAL FAILURE DUE TO				2 yrs		
				(C) DIABETES				9 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 8/2 19 67 to 8/5 19 67 , that (I) (we) lost saw the deceased alive on 8/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Joseph Gimbel M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/5/67				
23C. PHYSICIAN'S NAME (Type) JOSEPH GIMBEL M.D.				23D. ADDRESS SINAI HOSPITAL						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7578		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7578	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
			FLETCHER, ARTHUR H.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2311 Harlem Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE MARYLAND B. COUNTY		
5. SEX M.			6. RACE N.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			8. DATE OF BIRTH 12-9-1911		
9. AGE (In years last birthday) 55			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
13. FATHER'S NAME WILLIAM E. fletcher			14. MOTHER'S MAIDEN NAME ANNIE GASKINS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-09-8097		
17. INFORMANT Mrs. Ethel Fletcher			ADDRESS 2311 Harlem Ave.		
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) CARCINOMATOSIS DUE TO (B) DUE TO (C)		
19A. DATE OF OPERATION 0			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12-14 1966 to 12-30 1966 that (I) (we) last saw the deceased alive on 12-30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.					
23A. SIGNATURE Eljah Saunders			23B. DATE SIGNED 8/8/67		
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS			23D. ADDRESS 3414 DUVALL AVE. Baltimore, MD 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk	
24D. LOCATION Arbutus, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967			
25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.			
25D. ADDRESS 1701 Laurens St					



BIRTH NO. 61-17618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7579

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KEVIN

JARNIGAN (JERIKEN)

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967

9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1150 Argyle Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

6/20/61

9. AGE (In years
last birthday)

6

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

IRVIN JARNIGAN

14. MOTHER'S MAIDEN NAME

Sandra Newton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Sandra Newton 1150 Argyle

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Neck
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Dolphin St. and Argyle Avenue

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8/5/67

(Hour)

9:25

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. was shot by man
being chased by several youths.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

8/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-9-67

23C. NAME of CEMETERY or CREMATORY

MT CALVARY

23D. LOCATION

(City, town, or county)

A.A. Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 8 1967

Robert E. Feltner

Morton + Dyett

1701 LAURENS

Irvington
Student School
G.H.

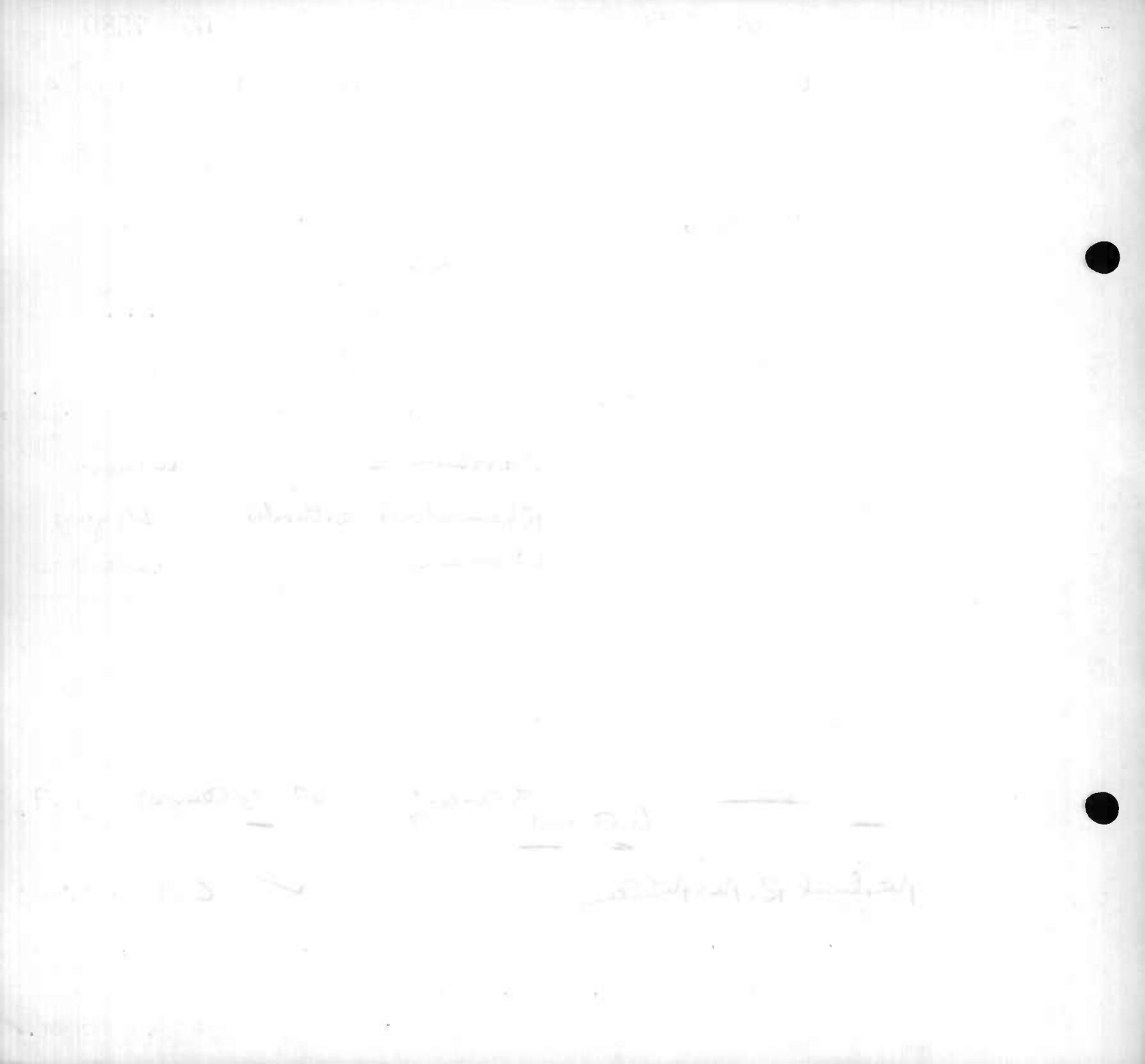
6/20/61
Sandra Weston
Sandra Weston
Sandra Weston

Point 8-8-61 Mt Calvary A.A.C.
Mason - The

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-100		67. 7580		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7580	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				6 AUGUST 1967 9:10 A.M.			
ELSLIE M. RUBIO							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND				MARYLAND			
31				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
D. STREET ADDRESS (If rural, give location)				14-02			
1608 DIVISION ST. 21217							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
FEMALE		NEGRO		MARRIED		12-25-01	
9. AGE (In years lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
65				VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JESSE WOODY				LAURA BAILEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				215-03-2472B		ADDRESS	
				RECORDS: BCH 4940 EASTER N AVENUE BALTO. 21224,		MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
199.21				Carcinoma		unknown	
ANTECEDENT CAUSES				Rheumatoid arthritis		27 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Anemia		unknown	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3 August 1967 to 6 August 1967, that (I) (was) last saw the deceased alive on 6 August 1967 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Michael R. McMillian				6 August 1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. MICHAEL R. MC MILLIAN				4940 EASTERN AVE. BALTIMORE 21224, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-10-67		Balto. Nat'l. Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 8 1967		Robert E. Faldy		Kelson Funeral Home 1348 Calhoun St.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7581

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE BERTHA JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967 6:20 pm

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1820 Pennsylvania Ave.

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

8-1-00

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Thomas

14. MOTHER'S MAIDEN NAME

Julia Ann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth Lee 1820 Pennsylvania Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) DUE TO Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

August 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-10-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Kelson

ADDRESS

Funeral Home 1348 Calhoun St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7582	
BIRTH NO. 67 7582		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Folson, Essie Mae		2. DATE AND HOUR OF DEATH August 4, 1967 3⁴⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 900 W. Lexington St.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W.	8. DATE OF BIRTH 2/25/48	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Camilla Ga.	
12. CITIZEN OF WHAT COUNTRY? U.S. of A.		13. FATHER'S NAME Wesley, William Watson		14. MOTHER'S MAIDEN NAME Bertha Tyse	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-5373		17. INFORMANT Chart of Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma, diffuse		CAUSE OF DEATH (A) DUE TO Scirrhus carcinoma @ breast		INTERVAL BETWEEN ONSET AND DEATH 8 Mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO		(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 1962		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (B) alone	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 0	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? 0		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 0	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 0		22. I certify that (I) (this hospital) attended the deceased from March 1962 to Aug 4 1967 , that (I) (we) last saw the deceased alive on August 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Gerald D. Becker		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/67	
23C. PHYSICIAN'S NAME (Type) University of Maryland Hospital		M.D. 23D. ADDRESS University of Maryland Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 8/8/1967		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial		24D. LOCATION (City, town or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home	
25D. ADDRESS 319 N. Schenck St.					

Friday, 10th May

10th May 1907

10th

University of Maryland Hospital

800 W. Lexington

Building

W H =

2/22/12

Apr 2nd

Mar 2nd

Washed William Watson

Center Type
Class of Building

10

Material - common brick

Scrub-Away concrete
Treated

1907

(10) 10th

10th

5

5

5

5

10th

10th

Howard G. Smith

University of Maryland Hospital

67 7583

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7583

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

S.

NORMAN MIKEL

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967

5:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1832 E. Fairmont Ave.

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

1832 E. Fairmont Ave. D.O.A.

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Male

White

NEVER MARRIED

FEB. 12, 1930

37

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BARTENDER

10B. KIND OF BUSINESS OR INDUSTRY

TAVERN

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN MIKEL

14. MOTHER'S MAIDEN NAME

STELLA NOVAK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

DANIEL MIKEL 1832 E. FAIRMOUNT AV.
21231

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Cirrhosis of the liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-9-67

23C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

W. FIALKOWSKI

ADDRESS

2007 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 7584		CERTIFICATE OF DEATH		67 7584	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAUERHAN, EDWARD ARTHUR		2. DATE AND HOUR OF DEATH AUGUST 6, 1967 10:20P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balts. Co.			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVES BALTIMORE, MD. 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND 21207 53-00			
		D. STREET ADDRESS (If rural, give location) 5929 JOHNNYCAKE RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 06-07-15	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CLERK		10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME CHARLES F. MAUERHAN			
14. MOTHER'S MAIDEN NAME EDNA HAHN (DECEASED)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 218 07 1433		17. INFORMANT Mrs. Harold Norris-5929 Johnnycake Rd. CATON & WILKENS			
18. 782-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Sudden Cardiac Failure DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 6 JULY 30 1967 to 19 67 AUGUST 6 19 67 and that (we) last saw the deceased alive on AUGUST 6 JULY 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Romualdo R. Dato		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/67	
23C. PHYSICIAN'S NAME (Type) Romualdo R. Dato		23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/9/67	24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gardens		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR R. E. Farley, MA		25C. FUNERAL DIRECTOR Witzke F. D. ADDRESS - 4101 Edmondson Ave.	

— *John G. Thompson*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7585		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7585	
M.E. CASE NO.		VIRGINIA		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Anna Bagusin		2. DATE AND HOUR OF DEATH 8/5/67 12 noon M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33 Baltimore, Md 21205		A. STATE MARYLAND B. COUNTY Balto Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5726 Cross Country Blvd			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/20/88	9. AGE (In years, last birthday) 83	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Balto. Co. Nr. Cockeysville	
13. FATHER'S NAME Tracey Orrich (ORRICK TRACEY)		14. MOTHER'S MAIDEN NAME Ellen Bamber			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-34-281B		17. INFORMANT: Hosp & Husband ADDRESS Dr. A.M. Bagusin 5726 Cross Country Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory Arrest DUE TO (B) Refractory Pulmonary Edema DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH 5 min 9 hours 20 years.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from July 29 1967 to Aug 5 1967, that (1) (we) last saw the deceased alive on Aug 5 1967 and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Sharp		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/5/67	
23C. PHYSICIAN'S NAME (Type) John R. Sharp		23D. ADDRESS M.D. Johns Hopkins Hospital, Balto, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug. 8/67		24C. NAME OF CEMETERY OR CREMATORY (Methodist Church) POPLAR GROVE CEMETERY	
24D. LOCATION off Warren Road, Warren, Maryland		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Stewart & Mowen Co. 108 W. North Av., City	

John Hopkins Hospital
Baltimore, Md 21202

3/30/83 3:45
Star Line County Blvd
Baltimore

Female White Married

Tracy Orrick

Ellen Bamber

317-34-3118

John R. Sharp

John Hopkins Hospital, Baltimore, Md

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7586				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7586	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ballenger, Nellie M.				2. DATE AND HOUR OF DEATH 8-5-67 10:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. Baltimore, Maryland 21217		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 16-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 930 N. XXXXX Street, Carrollton Ave.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 19, 1923	9. AGE (In years last birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) South Carolina
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Worcester Beeks				14. MOTHER'S MAIDEN NAME Viola Young			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220 24 9739		17. INFORMANT Mrs. L. Viola Beeks, Mother, Greenville		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 331X I CAUSE OF DEATH Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-4-67 19 to 8-5-67 19, that (I) (we) lost saw the deceased alive on 8-5-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Tengco				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-7-67	
23C. PHYSICIAN'S NAME (Type) Tengco				23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 12, 67		24C. NAME of CEMETERY or CREMATORY West Haven Mem. Park, Greenville, S. C.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farkema		25C. FUNERAL DIRECTOR John M. Johnson, 1700 Druid Hill		ADDRESS	

August 18 1864

John

1
N-655

67 7587

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 7587

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT NORMAN

2. DATE AND HOUR PRONOUNCED DEAD

August 2, 1967

6:45 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1417 E. Preston Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

5/3/11

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tenn.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

4/20/45-2/6/46

16. SOCIAL
SECURITY NO.

206-01-0977

17. INFORMANT

ADDRESS

Richard H. Croomes 1417 E. Preston

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute bronchiopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Chronic pulmonary emphysema
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/7/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7588		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7588	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William H. Frazier		8/3/67		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 15-11	
3400 Lynchester Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3400 Lynchester Road	
5. SEX M.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 10/16/98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Frazier		14. MOTHER'S MAIDEN NAME Martha		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lila Mae Frazier 3400 Lynchester Rd.	
18. 444 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART DISEASE (B) ESSENTIAL HYPERTENSION (C) SLIM		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CONGESTIVE FAILURE.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 1965 to AUGUST 3 1967 , that (I) (we) last saw the deceased alive on AUGUST 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE GILBERT L. BANFIELD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) GILBERT L. BANFIELD				23D. ADDRESS 722 N. FULTON Ave Balt Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Charles A. Rice	
25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.					

INTERSCATTERED POINT
DISTRIBUTION
ESTIMATED BY
BENT

CONCENTRIC POINTS

Point 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

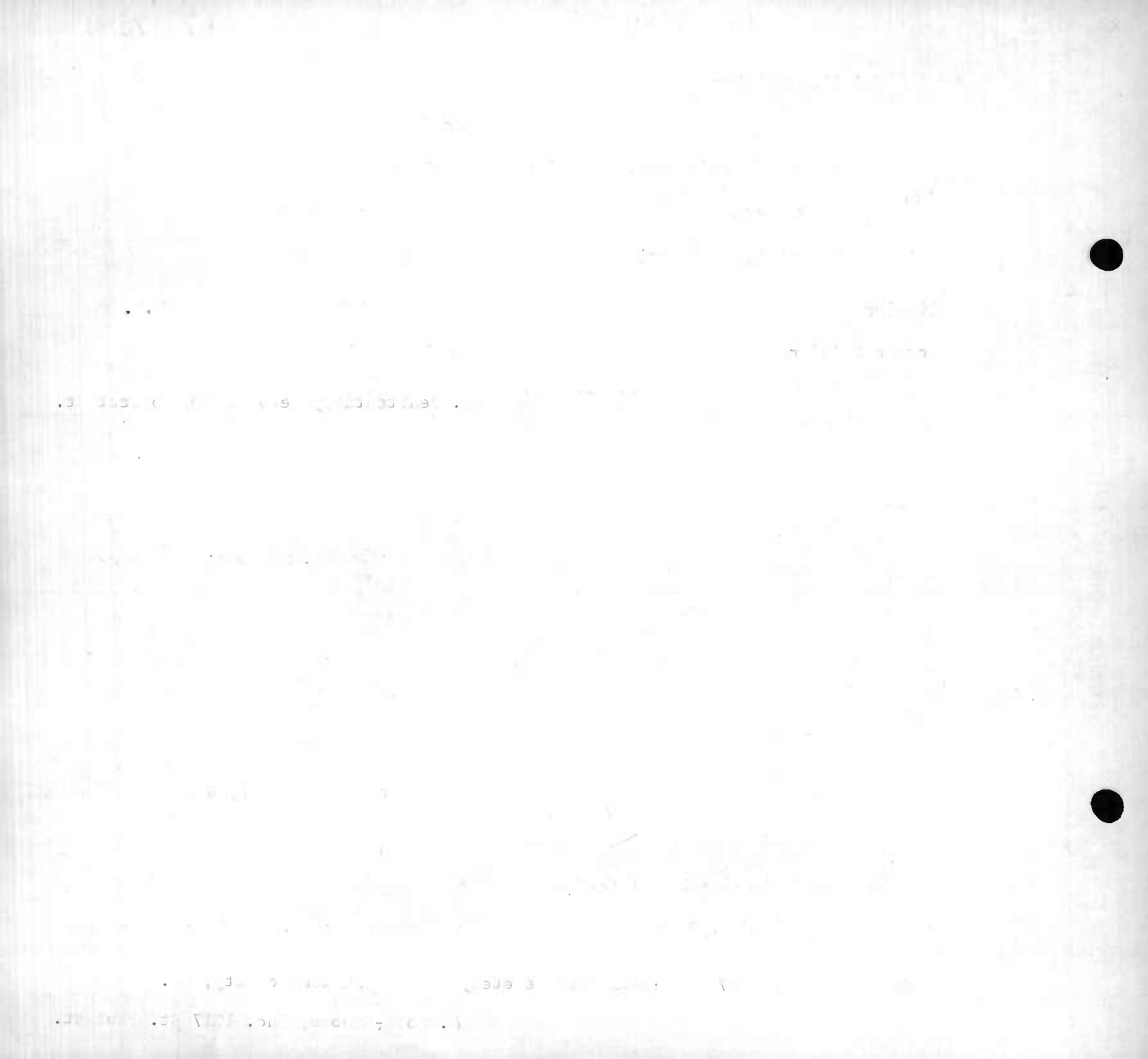
Point 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Point 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 7589		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7589	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				William Spitler	
2. DATE AND HOUR OF DEATH		2 Aug 67 7:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
92 Maryland Penitentiary Hospital 954 Forrest Street Baltimore, Maryland		Maryland			
5. SEX		6. RACE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Male		Caucasian		Baltimore	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Married		9 June 1937		30	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Glazier				West Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Arthur Spitler		Bernice Huff		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216 32 7465		Md. Penitentiary Records 954 Forrest St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) status Asthmaticus DUE TO		3 hrs	
		(B) Emphysema DUE TO		10 yrs	
		(C) Chronic Bronchitis		10 yrs	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 14 December 19 65 to 2 August 19 65, that (I) (we) last saw the deceased alive on 1 Aug 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Conrad Acton M.D.				2 Aug 67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Conrad Acton		954 Forrest Street, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/5/67		Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State)		Baltimore City, Md.			
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 8 1967		Robert E. Taney, Jr.		Wm. Cook-Brooks, Inc. 1217 St. Paul St.	



1
P-600

67 7590

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7590

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY E. PERRY

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1967 1:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2119 Parksley Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2119 Parksley Ave.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1/13/81

9. AGE (in years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Grammer

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Perry

ADDRESS

Thomas E. ~~PERRY~~ 2119 Parksley Ave Balt.Md.

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of uterus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/7/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

1217 St. Paul St.
Wm. Cook-Brooks Inc. Baltimore, Md. 21202

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. X 67 7591	
<div style="display: flex; justify-content: space-between;"> 13-2515 67 7591 CERTIFICATE OF DEATH </div>					
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Michael A. Bosman			2. DATE AND HOUR OF DEATH 8-6-67 10:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2906 Pennsylvania Avenue #21227		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-25-89	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY Kriel Packing Co.		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME William Bosman			12. CITIZEN OF WHAT COUNTRY? U.S.A..		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-0613		17. INFORMANT Walter Bosman
			ADDRESS 3061 Freeway		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IX			CAUSE OF DEATH (A) Cerebral Arteriosclerosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cerebral Artery Thrombosis DUE TO		1 year
			(C) Cerebral Vascular Disease DUE TO		1 day
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1967 to August 5 1967 , that (I) (we) last saw the deceased alive on August 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>did not</u> view the body after death.					
23A. SIGNATURE Paul Schorfeld				23B. DATE SIGNED 8/8/67	
23C. PHYSICIAN'S NAME (Type) Schorfeld, Paul				23D. ADDRESS 2301 Amnapro Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.	
				1217 St. Paul st. Balto. Md. 21202	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7592	
BIRTH NO. 67 7592		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Roy Lester Conner</i>		2. DATE AND HOUR OF DEATH <i>11:30 PM DST 8/5/67</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>28 USPHS Hospital</i>		A. STATE <i>Indiana</i> B. COUNTY <i>-</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Mishawaka V-12</i>			
		D. STREET ADDRESS (If rural, give location) <i>15551 E. 18th ST.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>5/9/1913</i>	9. AGE (In years lost birthday) <i>54</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector of airplane parts</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Amer</i>		13. FATHER'S NAME <i>John B. Connor</i>		14. MOTHER'S MAIDEN NAME <i>Florence Shelton</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>396-05-7495</i>		17. INFORMANT <i>Roy L. Conner</i>	
18. <i>204.31</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Acute Myelogenous Leukemia</i>			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>0</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>0</i>			
21D. TIME OF INJURY (APPROX.) <i>0</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>0</i>	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>this Hosp 7/26</i> 19 <i>67</i> to <i>8/5</i> 19 <i>67</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>8/5</i> 19 <i>67</i> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <i>Henry S. Crist</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/5/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Henry S Crist</i>		23D. ADDRESS <i>USPHS Hospital, Baltimore, md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Chapel Hill Memorial</i>	
24D. LOCATION <i>St. Joseph Co., Indiana</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7593		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7593	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 8/6/67 3:08 P.M.	
1. NAME OF DECEASED (Type or Print) Willie B. Bryant		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland		5. SEX M	
6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11/13/24	
9. AGE (in years last birthday) 42		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler		10B. KIND OF BUSINESS OR INDUSTRY Trucking Co	
11. BIRTHPLACE (State or foreign country) Courtland, Va		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Bernard Bryant	
14. MOTHER'S MAIDEN NAME Alice Crutchfield		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Leashia Bryant		ADDRESS 2461 Druid Hill Ave		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO Bronchogenic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH unknown	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16 19 67 to 8/6 19 67, that (I) (we) last saw the deceased alive on 8/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Thompson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type) Alvin Thompson		M.D. 23D. ADDRESS 1856 N. Wolfe St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-67		24C. NAME OF CEMETERY or CREMATORY Courtland Cemetery	
24D. LOCATION Courtland, Va		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Edgar L. Lynch		ADDRESS 2463 Druid Hill Ave			

67 7594

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7594

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD RICE

2. DATE AND HOUR PRONOUNCED DEAD

August 2, 1967 10:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

410 E. Chase Street

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

B. DATE OF BIRTH

9. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Male

Colored

Widower

Sept 28 1889

77

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

No.

Mark Smith 410 E Chase St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral vascular Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

100

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FUNERAL DIRECTOR: IMPORTANT

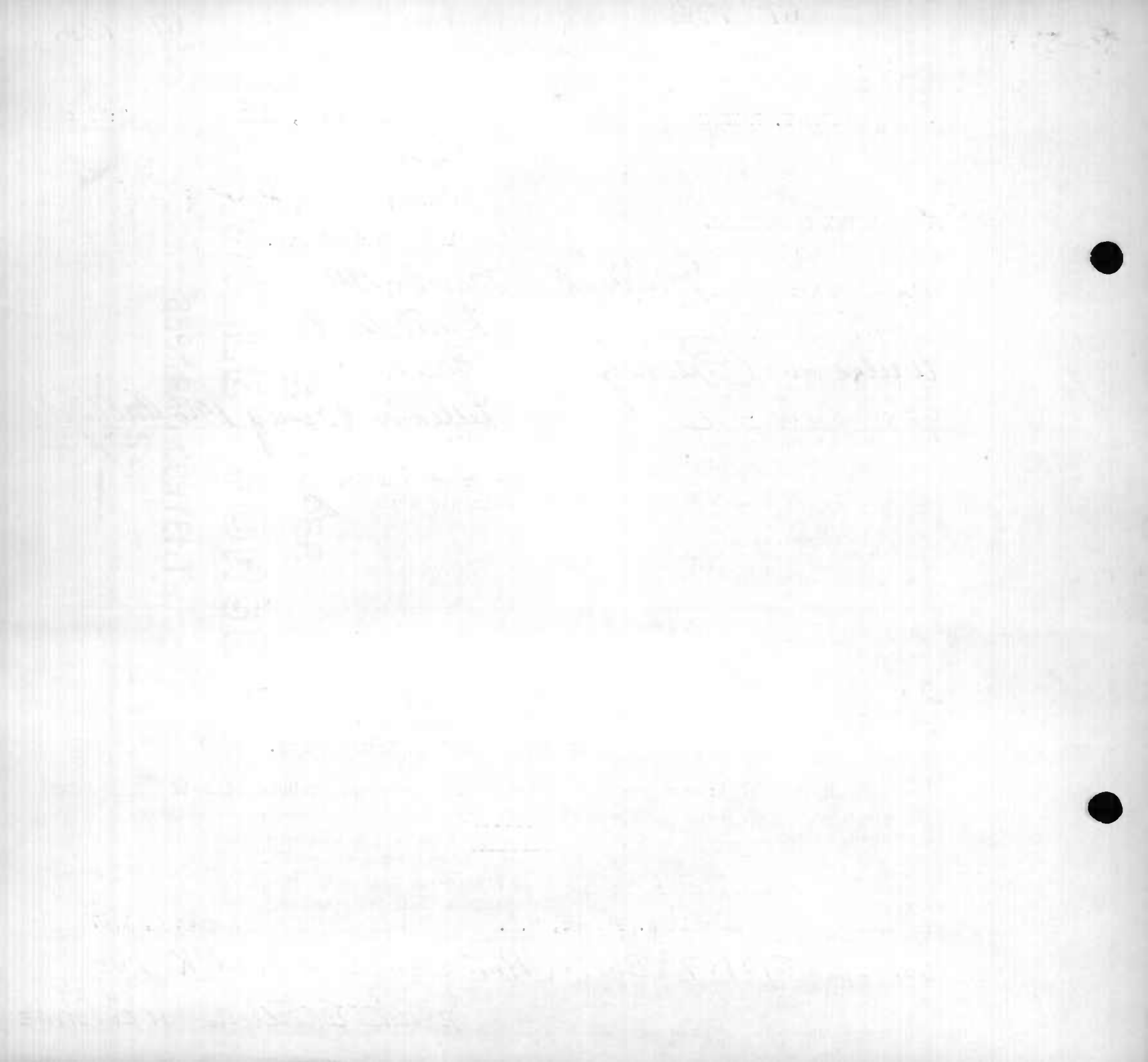
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7595		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7595	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) WILLIE ALEXANDER		
2. DATE AND HOUR OF DEATH 8-6-1967 10,30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 5 7-04			D. STREET ADDRESS (If rural, give location) 1046 N. BROADWAY		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 9-2-18	9. AGE (In years, lost birthday) 48 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Atlanta Ga	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WILLIAM Alexander		14. MOTHER'S MAIDEN NAME LULA TOLIVER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) World War II		16. SOCIAL SECURITY NO.		17. INFORMANT Willie Mae Brandt ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Recurrent Pul TB (B) DUE TO Chronic Obstructive Disease of the Airways (C)		INTERVAL BETWEEN ONSET AND DEATH 2-3 years Many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28/67 19 to 8/6/67 19 that (I) (we) last saw the deceased alive on 8/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Stone				23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type or Print) DR. JOHN STONE				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Buried Aug 10/67		24C. NAME of CEMETERY or CREMATORY Bred Mt Cem.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR Zora T. Eliseon 1129 N. Calhoun		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Taney, M.D.		25C. FUNERAL DIRECTOR Zora T. Eliseon 1129 N. Calhoun	

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67 7597 BALTIMORE CITY HEALTH DEPARTMENT

67 7597

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Josephine ROSPHINE QUEEN

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967 9:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1618 Dallas Street

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1618 Dallas Street D.O.A.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept 20 1903

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George W. Johnson

14. MOTHER'S MAIDEN NAME

Josephine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Harry Queen 1618 Dallas St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

ELLY POHLE

STADT HANNOVER

1914

1914

BIRTH NO.		M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) RALPH		2. DATE AND HOUR PRONOUNCED DEAD August 5, 1967		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SOUTH BALTIMORE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-01	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 5-21-1922	
9. AGE (In years last birthday) 45		10. AGE (In years last birthday) 45		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing		10B. KIND OF BUSINESS OR INDUSTRY Roofing		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Brigman		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 238 20 9110	
17. INFORMANT Mrs. Betty R Brigman		18. ADDRESS 1426 Hanover St S		19. CAUSE OF DEATH Laceration of Liver and Kidney		INTERVAL BETWEEN ONSET AND DEATH	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. MEDICAL CERTIFICATION	
24. DATE OF OPERATION 8/3/67		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
28. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ostend Street W. of Sharp Street		31. HOW DID INJURY OCCUR? Subj driver - vehicle struck bridge abutment.	
32. TIME OF INJURY (APPROX.) 8/3/67		33. INJURY OCCURRED 21D. (Month) (Day) (Year) (Hour) (Minute) 9:40 P. m.		34. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		35. DATE SIGNED 8/6/67	
36. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		37. ACTUAL SIGNATURE Werner U. Spitz, M.D.		38. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		39. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
40. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		41. DATE SIGNED 8/6/67		42. BURIAL CREMATION, REMOVAL (Specify) Burial		43. DATE 8-10-67	
44. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		45. LOCATION (City, town, or county) (State) Baltimore, Md.		46. DATE REC'D BY HEALTH DEPT. AUG 8 1967		47. NAME OF REGISTRAR Robert E. Finkbeiner	
48. FUNERAL DIRECTOR Thomas J. Kenny Inc Balto. Md.		49. ADDRESS		50. VS 151-REV. 1/1/65		51. N 869.2	

WALLLEY REPORT

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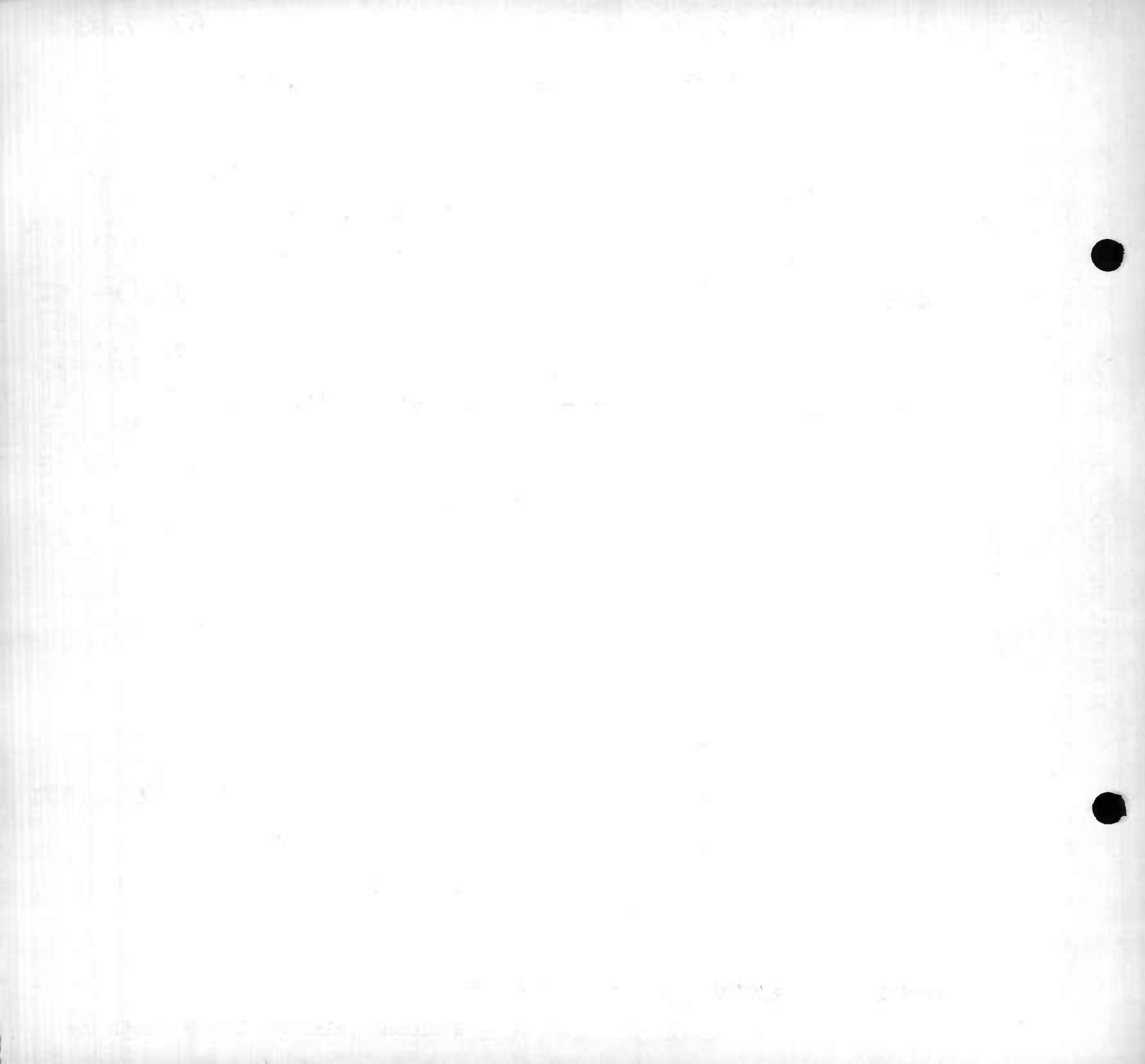
WALLLEY REPORT

WALLLEY REPORT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7599		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7599	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William Hart		August 5, 1967		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
90 MidTown Nursing Home		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give to what ship)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		808 St Paul St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years, last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	C	W	7/15/91	75	76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cook				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
				U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-10-8816		Mrs Louise Watties 2621 Boone St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Sudden	
ANTECEDENT CAUSES		(B) DUE TO		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Residual Paresis from older C.V.A.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 7 1967 to Aug 5 1967, that (I) (we) last saw the deceased alive on Aug 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 7 P.M.					
23A. SIGNATURE		23B. DATE SIGNED			
Joseph S. Blum M.D.		8/7/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOSEPH S. BLUM M.D.		1115 N. Calver St			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	8/9/67	1st Calvary cemetery	A A County Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
AUG 8 1967	Robert E. Farley	Adolphus Halstead 1206 W North Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7600				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7600	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EVA BROWN				2. DATE AND HOUR OF DEATH AUGUST 2, 1967 4 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL OF MD. 730 ASH BURTON STREET BALTIMORE, MARYLAND 21201				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1152 N STRICKER			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2-20-20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Brown				14. MOTHER'S MAIDEN NAME Cl ara			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-24-3177		17. INFORMANT ADDRESS Mrs Mary Manning, same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) E902.10 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Pulmonary Embolism (B) DUE TO Fracture - dislocation, ankle, (R) (C) a fall		INTERVAL BETWEEN ONSET AND DEATH	
				19A. DATE OF OPERATION 7/28/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture - dislocation, ankle (R)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1152 N. STRICKER ST. BALTY, MD		21D. TIME OF INJURY (APPROX.) 7 15 1967 AM	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down the fire escape 16-02					
22. I certify that (I) (this hospital) attended the deceased from 7/15 19 67 to 8/2 19 67 that (I) (we) last saw the deceased alive on 8/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Desiderio L. Hebron, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/2/67	
23C. PHYSICIAN'S NAME (Type) DESIDERIO L. HEBRON, JR.		23D. ADDRESS M.D. Lutheran Hospital of Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/7/67	24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Adolphus H. Alstead		ADDRESS 1206 W North Ave	

Dr. will not sign until Report is Received
from Hospital - 7/16/68
8743

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67. 7601		67. 7601	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		EUGENE VENEY		2. DATE AND HOUR OF DEATH 8/6/67 3 48 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI Hosp		A. STATE MARYLAND B. COUNTY 27-16 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4664 PARK HEIGHTS AVE.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/17/16	9. AGE (In years last birthday) 51	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Thomas Veney			14. MOTHER'S MAIDEN NAME Lila		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Emma Veney, same ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 330X1 SUBARACHNOID HEMORRHAGE			INTERVAL BETWEEN ONSET AND DEATH 17 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/21/67 19 to 8/6/67 19 that (I) last saw the deceased alive on 8/6/67 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE Barry M. Potter M.D.				23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type) BARRY M. POTTER		23D. ADDRESS SINAI Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/67		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) A A County Md		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <i>Pennsylvania</i> 67 7602		CERTIFICATE OF DEATH		67 7602	
1. NAME OF DECEASED (Type or Print) Andrew Snyder			2. DATE AND HOUR OF DEATH 8/7/67 8:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY Greencastle C. CITY OR TOWN (If outside city limits, write RURAL and give township) R.F.D. # 2 V-35 D. STREET ADDRESS (If rural, give location)		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) —	8. DATE OF BIRTH 4/5/64	9. AGE (In years lost birthday) 3yr	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Melvin Snyder			14. MOTHER'S MAIDEN NAME Joan Fry Greencastle, Pa R.F.D. # 2		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 572.1 Alimentary catitis			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO W.K.W.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/7 1967 to 8/7 1967 , that (I) (we) last saw the deceased alive on 8/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harriet E. Guild			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/7/67
23C. PHYSICIAN'S NAME (Type) HARRIET E. GUILD			23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8/7/67		24C. NAME OF CEMETERY or CREMATORY Orbisonia, Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1967		25B. NAME OF REGISTRAR Robert E. Faldy		25C. FUNERAL DIRECTOR Wm. J. Fickert Sons	
ADDRESS North 8 Pa Ave Balto, Md 21217					

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FUNERAL DIRECTOR: IMPORTANT

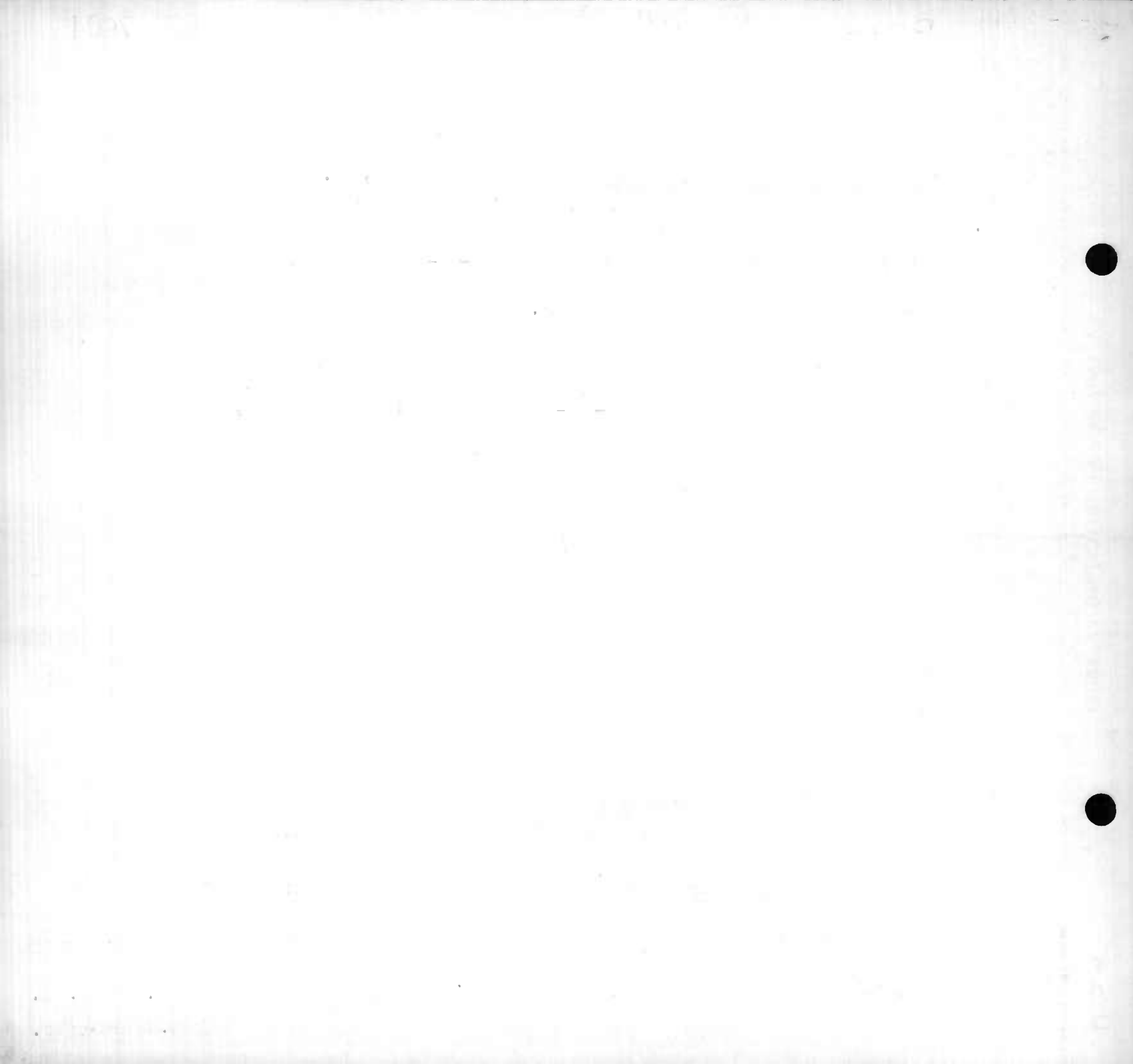
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <u>Delaware 67. 7603</u>		CERTIFICATE OF DEATH		87 7603	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) COLEN R. WHITE JR.			
2. DATE AND HOUR OF DEATH 8-2-67 7:50 AM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE DELAWARE B. COUNTY SEAFORD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEAFORD D. STREET ADDRESS (If rural, give location) 2207 CONCORD ROAD			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 4-24-67	9. AGE (In years last birthday) 3 9	(If Under 1 Yr. Months Days) (If Under 24 Hrs. Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME COLEN R. WHITE SR.		14. MOTHER'S MAIDEN NAME MARGUERITE PALMER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Marguerite White Seaford, Del.	
18. CAUSE OF DEATH 254.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Tetralogy of Fallot		INTERVAL BETWEEN ONSET AND DEATH 15 min. 2 hr. 3 mos.			
19A. DATE OF OPERATION 8/1/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tetralogy of Fallot		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 7/31 19 67 to 8/2 19 67 , that (X) (we) last saw the deceased alive on 8/2 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Denis H. O'Neal				23B. DATE SIGNED 8/2/67	
23C. PHYSICIAN'S NAME (Type) DENIS H. O'NEAL		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/67		24C. NAME OF CEMETERY OR CREMATORY New Zion Cemetery	
24D. LOCATION Laurel, Del.		25A. DATE REC'D BY HEALTH DEPT. Aug 9 1967			
25B. NAME OF REGISTRAR Salio M.		25C. FUNERAL DIRECTOR Robert E. Faldema			
25D. ADDRESS					

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

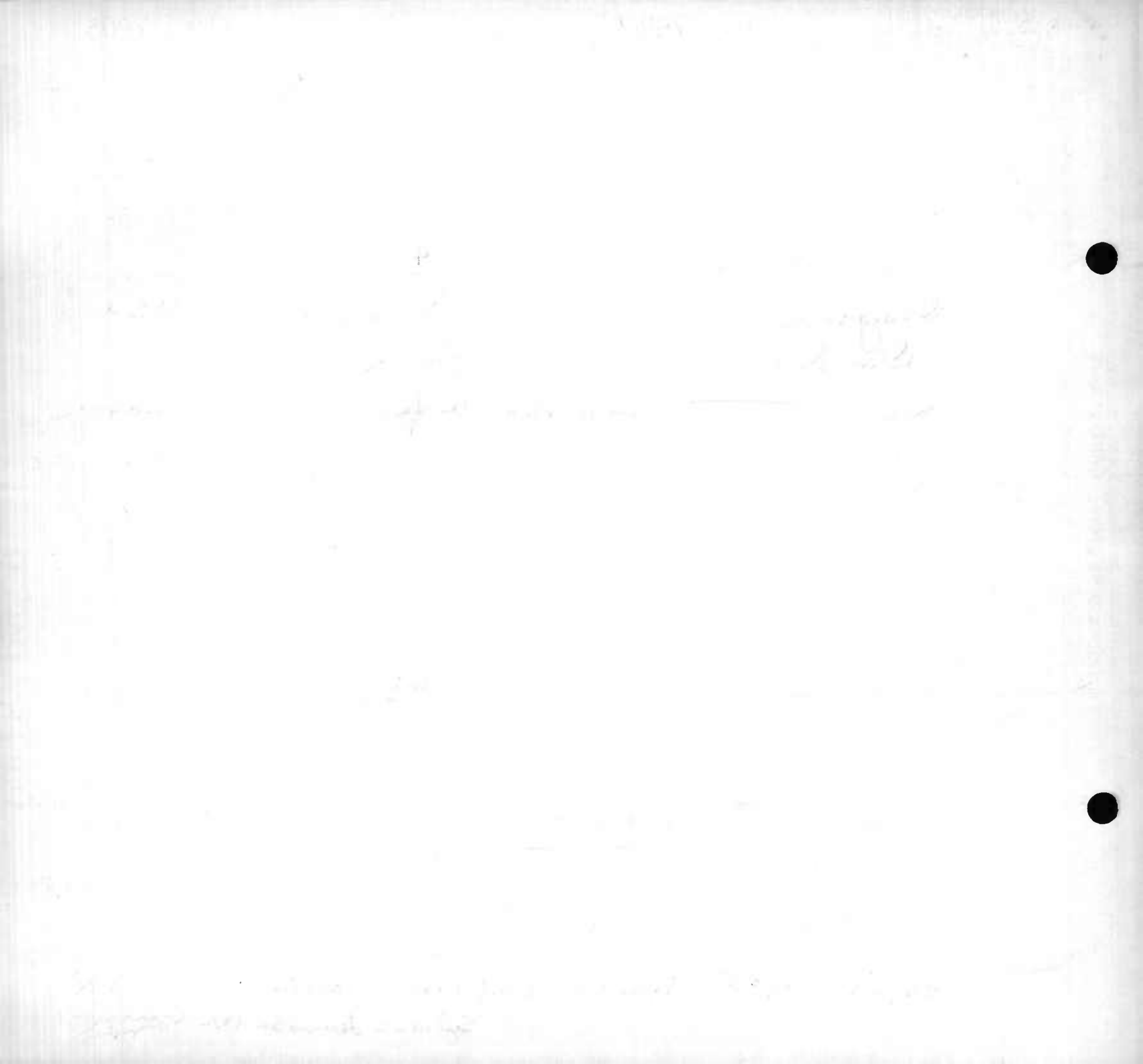
B-626		67 7604		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7604	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Berger		2. DATE AND HOUR OF DEATH 8/6/67 1:30 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. 00-00 D. STREET ADDRESS (If rural, give location) (Homeless)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8-21-1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY City of Balto.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Berger			14. MOTHER'S MAIDEN NAME Mary Steinback				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W II		16. SOCIAL SECURITY NO. 215-14-9738		17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary tract infection Bronchitis + asthma				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8/5 19 67 to 8/6 19 67 , that (1) (we) last saw the deceased alive on 8/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Zachary Grossman M.D.				23B. DATE SIGNED 8/6/67		23C. PHYSICIAN'S NAME (Type) Zachary Grossman M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Old Frederick Rd. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Fash...		25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME ADDRESS 1216 S. Charles St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7805					67 7805				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Samuel Berger</u>					2. DATE AND HOUR OF DEATH <u>Aug 8 1967 6:55</u> <u>1</u> <u>A</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital / Baltimore, Inc.</u> <u>42</u>		(If not in hospital or institution, give street address or location)			A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>					D. STREET ADDRESS (If rural, give location) <u>1004 Bittersweet Ct.</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>1/4/84</u>	9. AGE (In years last birthday) <u>83</u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Designer</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David</u>				14. MOTHER'S MAIDEN NAME <u>Leah</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-10-6926</u>		17. INFORMANT <u>Wife</u>		ADDRESS <u>Same</u>	
18. <u>72211</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Ventricular tachycardia</u> DUE TO (B) <u>Acute Pulmonary edema</u> DUE TO (C) <u>Atherosclerotic Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 minutes</u> <u>9 days</u> <u>16 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 7</u> <u>19 67</u> to <u>Aug 8</u> <u>19 67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>August 8</u> <u>19 67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) <u>(did not)</u> view the body after death.									
23A. SIGNATURE <u>Benjamin Kropsky</u> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug 8, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Benjamin Kropsky</u> M.D.						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/10/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Grave Emergent City Chain</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fackey</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Levinson, INC</u>		ADDRESS <u>Germantown, MD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

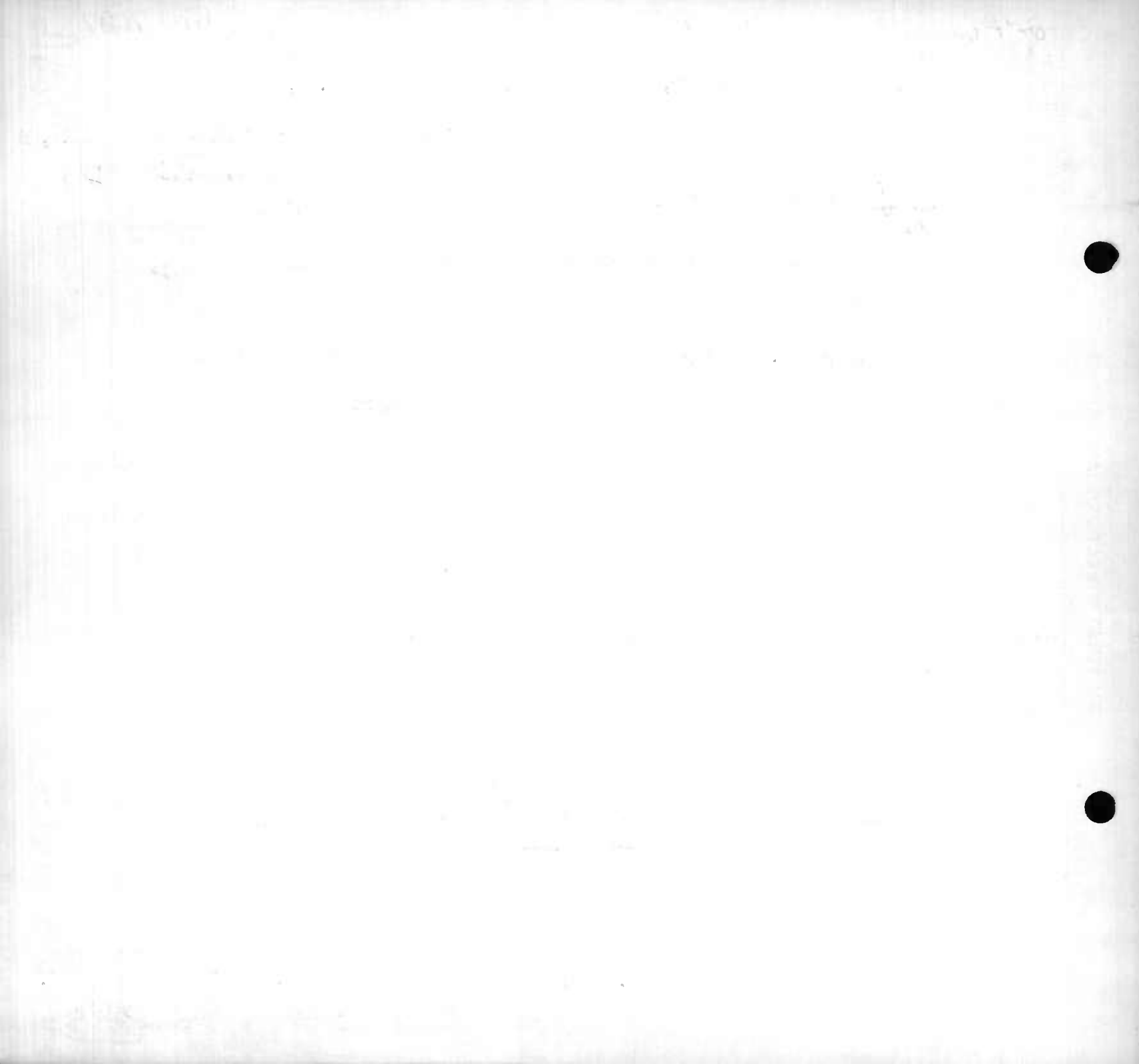
BIRTH NO. 67 7606				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7606	
1. NAME OF DECEASED (Type or Print) XIDIAS, Nick,				2. DATE AND HOUR OF DEATH August 5th 1967 11:58 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-07 D. STREET ADDRESS (If rural, give location) 4813 Fleet Street			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan I 1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-7570		17. INFORMANT Mrs. Sophia Xidias		ADDRESS 4813 Fleet St., Baltimore, Md. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism DUE TO (A) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____				INTERVAL BETWEEN ONSET AND DEATH 3 Hours			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia				16 days			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/20 19 67 to 8/5 19 67 , that (I) (we) lost saw the deceased alive on 8/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 8/5/67			
23C. PHYSICIAN'S NAME (Type) Jose MARTINEZ M.D.				23D. ADDRESS 100 N. Broadway 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-67		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Nicholas J. Matthews 3021 Eastern Ave., Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

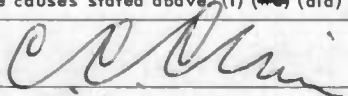
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

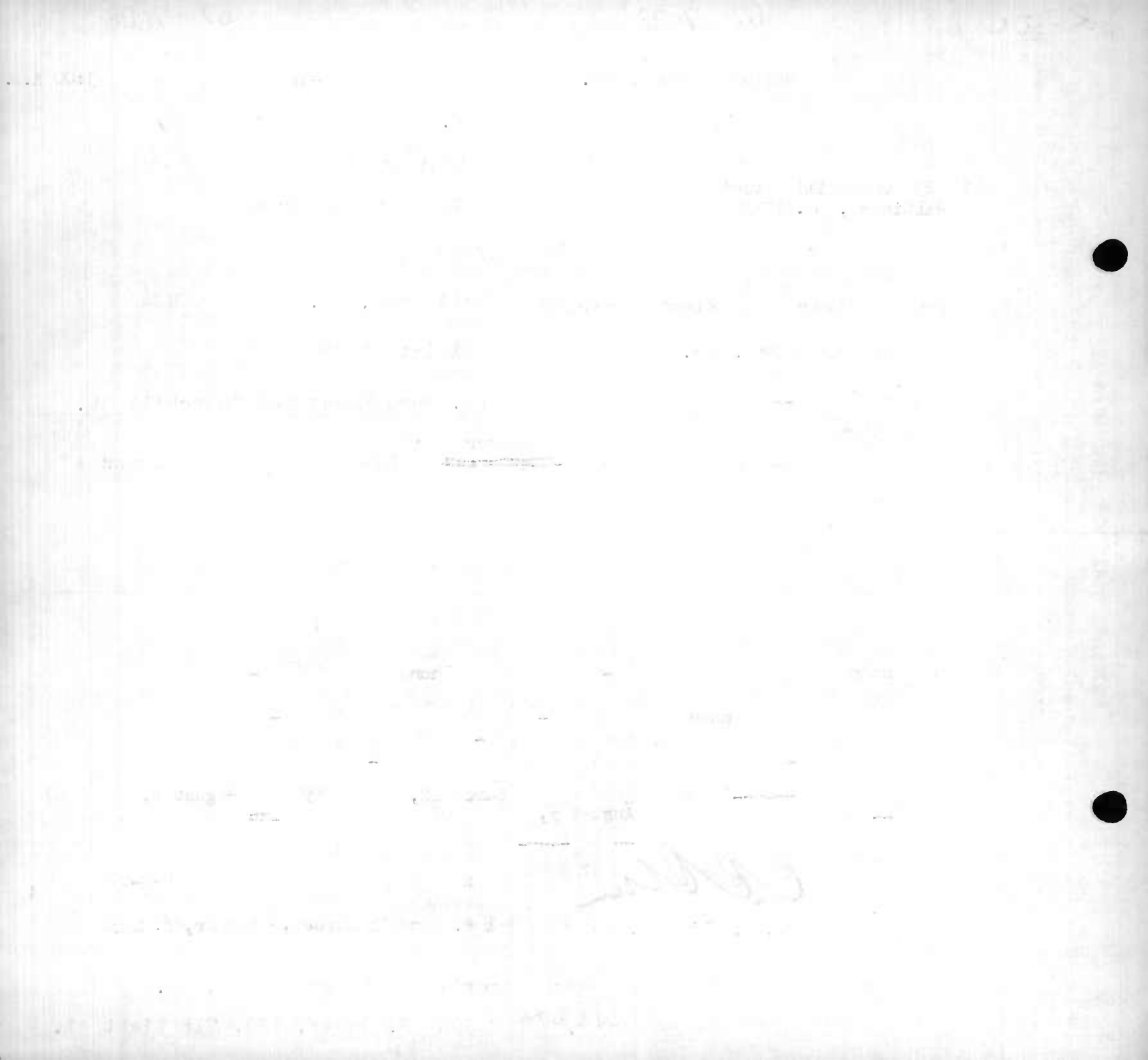
BIRTH NO. 67 7607				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 7607	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Bassler, Richard Thomas				Aug. 5, 1967					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				A. STATE B. COUNTY					
				Rosewood State Hospital - Owings Mills, Md					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ellicott City, Md				D. STREET ADDRESS (If rural, give location) 63-00 Cedar Lane rt 4					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 3/23/55	9. AGE (In years last birthday) 12	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Alfred S. Bassler				14. MOTHER'S MAIDEN NAME Patricia Peddicord					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Chart		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 04571 CAUSE OF DEATH Shigellosis (A) DUE TO Hypoproteinemia (B) DUE TO Anemia (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 16 days Unknown Unknown					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Chronic neurologic disease ? etiology				12 years					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 20 1967 to August 5 1967, that (I) last saw the deceased alive on August 5 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE Marston C. [Signature] M.D.						23B. DATE SIGNED August 5, 1967			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/8/67		24C. NAME of CEMETERY or CREMATORY Mt. View		24D. LOCATION Alpha ,		(City, town, or county) (State) Howard Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Highbottom-Slack Funeral Home		25D. ADDRESS Ellicott City Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

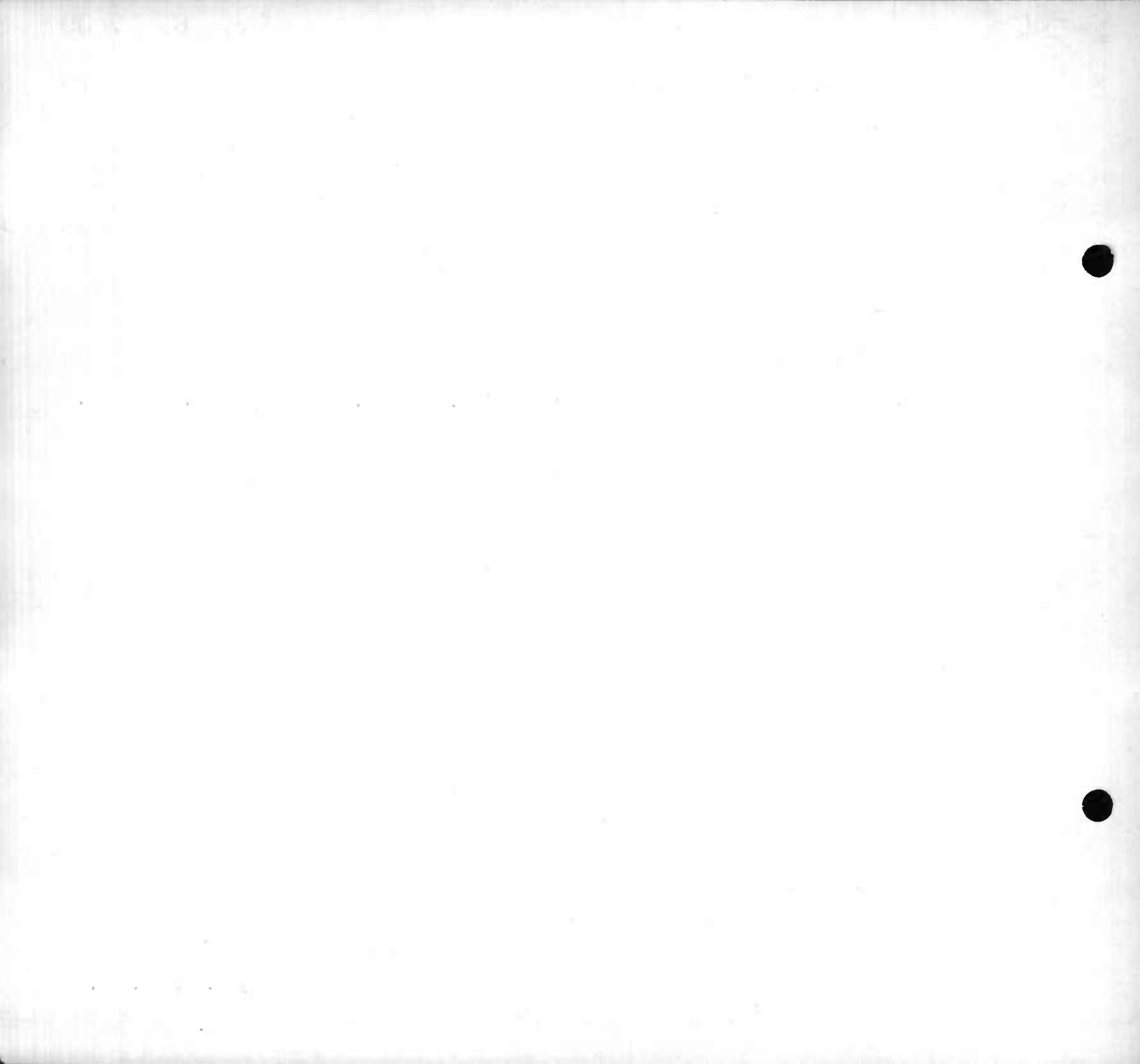
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7608	
BIRTH NO. 67 7608		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter Robey, Jr.		2. DATE AND HOUR OF DEATH 8-8-67 3:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 232 Churchill Street Baltimore, Md. 21230		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City 22-61 D. STREET ADDRESS (If rural, give location) 232 Churchill Street			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 6/11/1919	9. AGE (In years lost birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Floor Covering		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Robey, Sr.			
14. MOTHER'S MAIDEN NAME Violet Dietz		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mary Robey 232 Churchill St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer		19. CAUSE OF DEATH (A) Fractured of lungs DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 months	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) none	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (the hospital) attended the deceased from March 12, 1959 to August 8, 1967 , that (I) (we) last saw the deceased alive on August 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-67	
23C. PHYSICIAN'S NAME (Type) C. C. Chiu		23D. ADDRESS M.D. 1 E. Randall Street, Baltimore, Md. 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial	
24D. LOCATION Glen Burnie, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

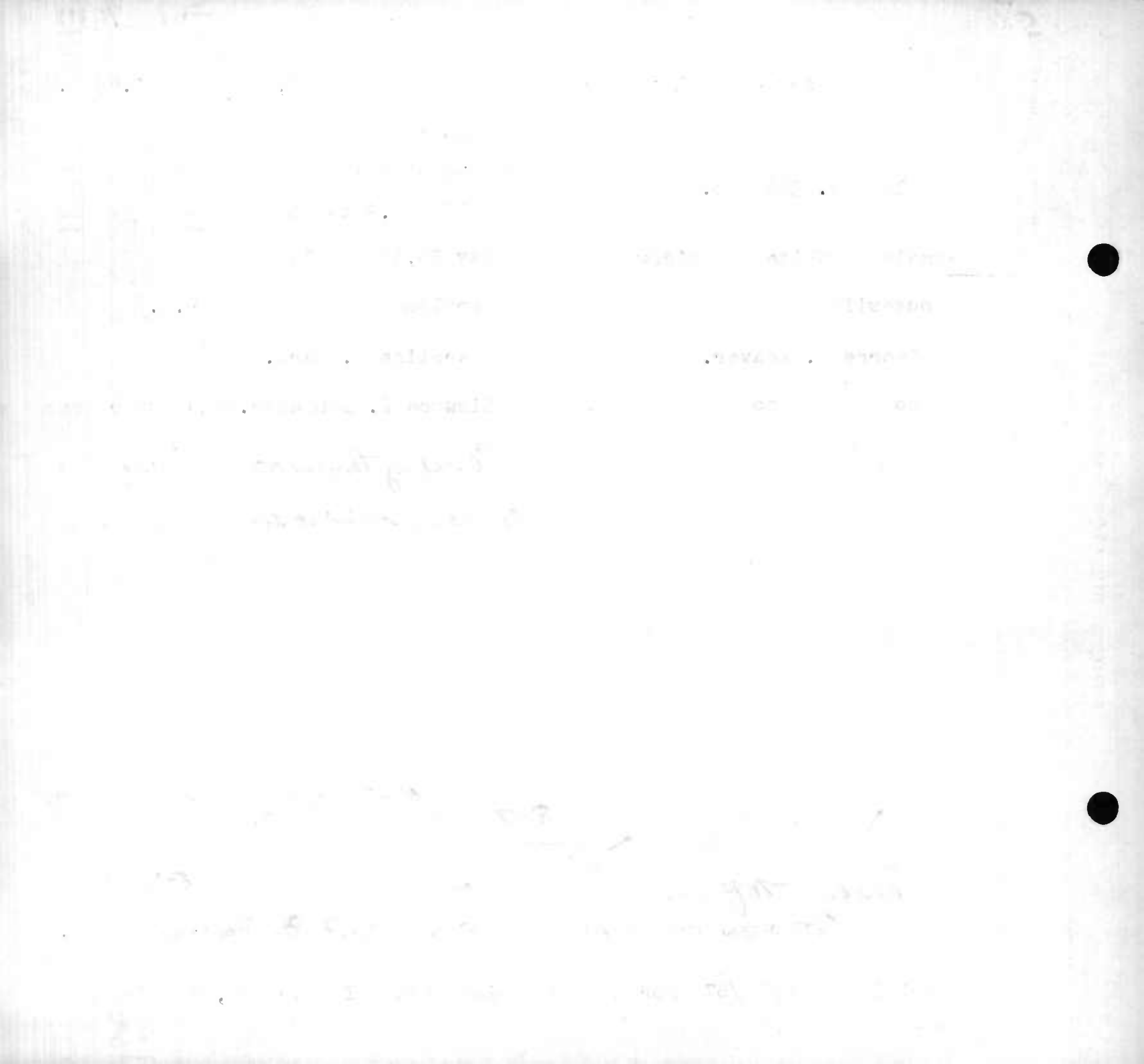
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 7609		CERTIFICATE OF DEATH		Registered No. 67 7609	
1. NAME OF DECEASED (Type or Print) Guy F. Swaggerty				2. DATE AND HOUR OF DEATH 8/8/1967 6:25 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore GENERAL Hosp. (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 23-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 D. STREET ADDRESS (If rural, give location) 8 West Cross St.					
5. SEX M.	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 7/2/1897	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner-Retired		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Swaggerty				14. MOTHER'S MAIDEN NAME Josie Pease					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 236 05 3681		17. INFORMANT ADDRESS Mrs. Allie G. Swaggerty 8 W. Cross St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162-11 DUE TO ① Bronchogenic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ② Left Atrial Sclerosis ③ Central Insufficiency				INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from 7-3 19 67 to 8-8 19 67 , that we (we) last saw the deceased alive on 8-8 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gonzalo F. Guacena, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/8/67			
23C. PHYSICIAN'S NAME (Type) Gonzalo F. Guacena, Jr.		23D. ADDRESS 1213 Light Street							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 11 67		24C. NAME of CEMETERY or CREMATORY Glen Haven		24D. LOCATION Glen Burnie, A. A. Co. Md.		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

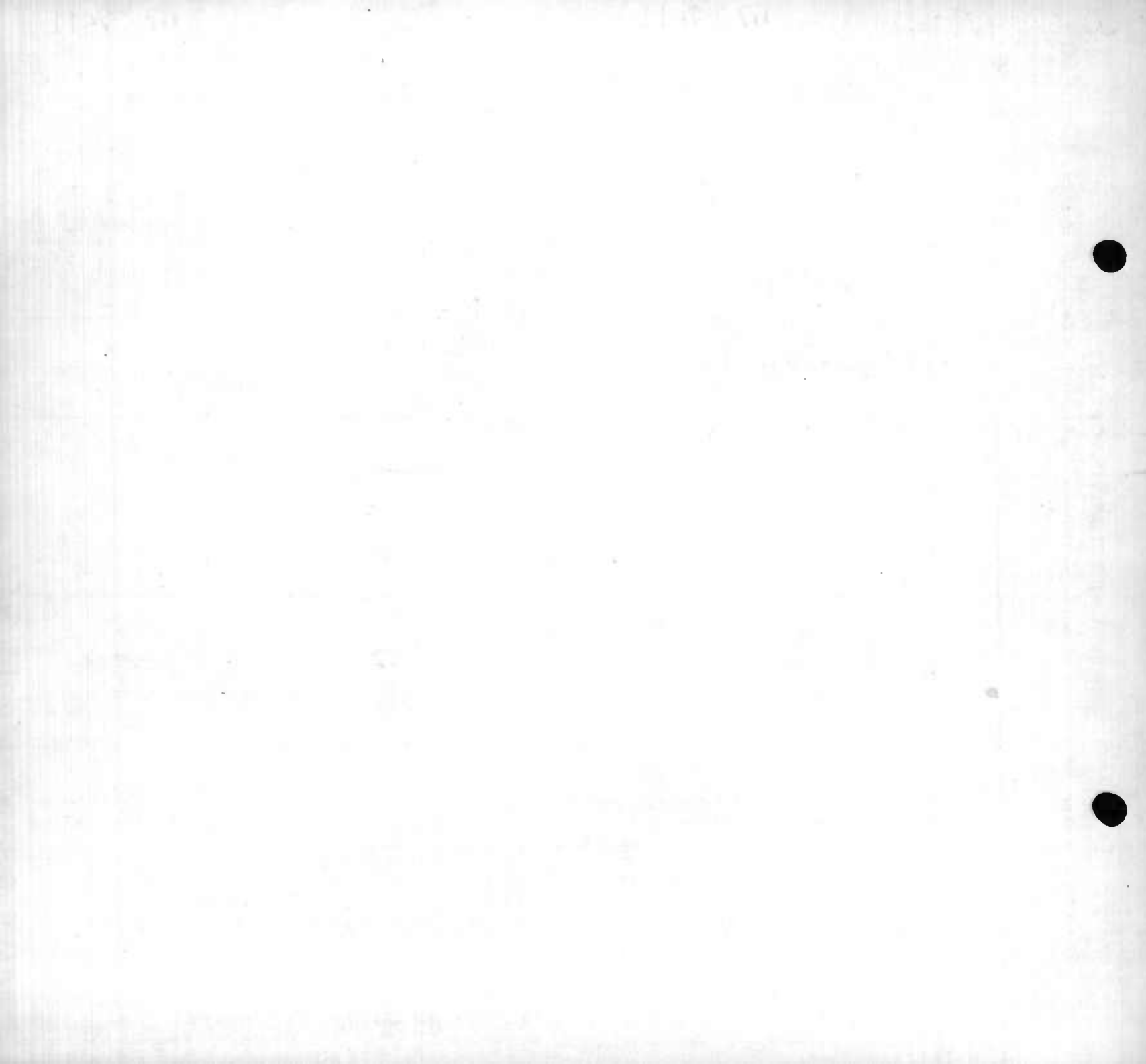
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7610		67 7610		67 7610	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Mary Jane Slenbaker		August 7, 1967 3:45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		B. COUNTY	
1505 W. 36th St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		1505 W. 36th St	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	Widow	May 20, 1888	79	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George W. Weaver.		Caroline M. Harn.		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no no		?		Linwood J. Slenbaker. 3710 Tudor Arms Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 I		Coronary thrombosis		May 1967	
ANTECEDENT CAUSES		(B) Coronary sclerosis		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		11-3 1953 to		8-7 1967	
that (I) (we) last saw the deceased alive on		8-7 1967		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Reuben Hoffman		8-7-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
REUBEN HOFFMAN M.D.		846 W. 36th St., BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/10/67		Moreland Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1967		Robert E. Farber		Austin E. Donovan-3818 Roland Ave	
				24D. LOCATION (City, town, or county) (State)	
				Taylor Ave, Md	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7811 4</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67-15224 67 7811</u> CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> M.E. CASE NO. <u>GIRL</u> 2. DATE AND HOUR OF DEATH <u>8/2/67</u> <u>2:00 A</u> M. </div>					
1. NAME OF DECEASED (Type or Print) <u>Baby of LILLIAN WYNN</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSPITAL</u> <u>36</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>16-63</u> D. STREET ADDRESS (If rural, give location) <u>647 N. FULTON AVE</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8/2/67</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>50 min</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Little John, Frank</u>			14. MOTHER'S MAIDEN NAME <u>LILLIAN WYNN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>776X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>IMMATURITY</u> (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C)					
INTERVAL BETWEEN ONSET AND DEATH <u>50 minutes</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Honorio R. Ylizarde</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8/2/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>HONORIO R. YLIZARDE</u> M.D.				23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>	
24A. BURIAL CREMATION? REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>FR. Sq. Hospital</u>	
24D. LOCATION (City, town, or county) <u>BALTO. Md.</u>		24E. (State)			
25A. DATE REC'D <u>AUG 9 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, Md.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>	



1
S-555

67 7612

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7612

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

WALTER

George

SCHNEENAN

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1967

6:50 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

801 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3322 Texas Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

7/28/1907

9. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Grain

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Schneeman

14. MOTHER'S MAIDEN NAME

Bertha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

21709 6145

17. INFORMANT

ADDRESS

Mr. Wm. Schneeman - 3 607 Hamilton Ave. #14

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Multiple Injuries

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Factory

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Sherwood Feed Company

801 Eastern Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute) Aug. 8 '67 6:30 A.

21E. INJURY OCCURRED

WHILE AT WORK ☒

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Subj. fell in mixer at Sherwood Feed Company

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

8.10/67

23C. NAME of CEMETERY or CREMATORY

Meadowridge Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 9 1967 Robert E. Farber, M.D.

Leonard J. Ruck Inc. 5305 Harford Rd. #14

1. The first part of the report is a general statement of the purpose and scope of the study.

2. The second part of the report is a description of the methods used in the study.

3. The third part of the report is a description of the results of the study.

4. The fourth part of the report is a discussion of the results of the study.

5. The fifth part of the report is a conclusion of the study.

6. The sixth part of the report is a list of references.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of figures.

9. The ninth part of the report is a list of tables.

10. The tenth part of the report is a list of footnotes.

11. The eleventh part of the report is a list of abbreviations.

12. The twelfth part of the report is a list of symbols.

13. The thirteenth part of the report is a list of definitions.

14. The fourteenth part of the report is a list of acronyms.

15. The fifteenth part of the report is a list of initialisms.

16. The sixteenth part of the report is a list of contractions.

17. The seventeenth part of the report is a list of abbreviations.

18. The eighteenth part of the report is a list of symbols.

19. The nineteenth part of the report is a list of tables.

20. The twentieth part of the report is a list of figures.

21. The twenty-first part of the report is a list of appendices.

22. The twenty-second part of the report is a list of references.

23. The twenty-third part of the report is a list of footnotes.

24. The twenty-fourth part of the report is a list of abbreviations.

25. The twenty-fifth part of the report is a list of symbols.

26. The twenty-sixth part of the report is a list of tables.

27. The twenty-seventh part of the report is a list of figures.

28. The twenty-eighth part of the report is a list of appendices.

29. The twenty-ninth part of the report is a list of references.

30. The thirtieth part of the report is a list of footnotes.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 7613		67 7613	
BIRTH NO. W-436		67 7613		Registered No. 67 7613	
M.E. CASE NO.		67 7613		67 7613	
1. NAME OF DECEASED (Type or Print) WALTERS, LOUIS P.		2. DATE AND HOUR OF DEATH 6 AUGUST 1967 3:12 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 103 Sufferage ROAD 21220			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 2-21-99	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis P. Walters		14. MOTHER'S MAIDEN NAME Margaret ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 214-18-3303		17. INFORMANT Frederick Walters, son, 21224, MD. RECORDS: BCH 4940 EASTERN AVE. BALTO.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ATHEROSCLEROTIC HEART DIS. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8-3 1967 to 8-6- 1967 , that (1) was last saw the deceased alive on 6 AUGUST 19 67 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (1) was (did) not view the body after death.					
23A. SIGNATURE Russell D Hicks		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6 AUGUST 1967	
23C. PHYSICIAN'S NAME (Type) DR. RUSSELL D. HICKS		23D. ADDRESS 4940 EASTERN AVE BALTIMORE Md 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967			
25B. NAME OF REGISTRAR P. D. A. E. F. D. E. M.		25C. FUNERAL DIRECTOR Schimunek Funeral Home			
25D. ADDRESS 3331 Brehms Lane #13					

MICHAEL J. HARRIS

Administrative Services Unit

6 June 1971

James D. Harris

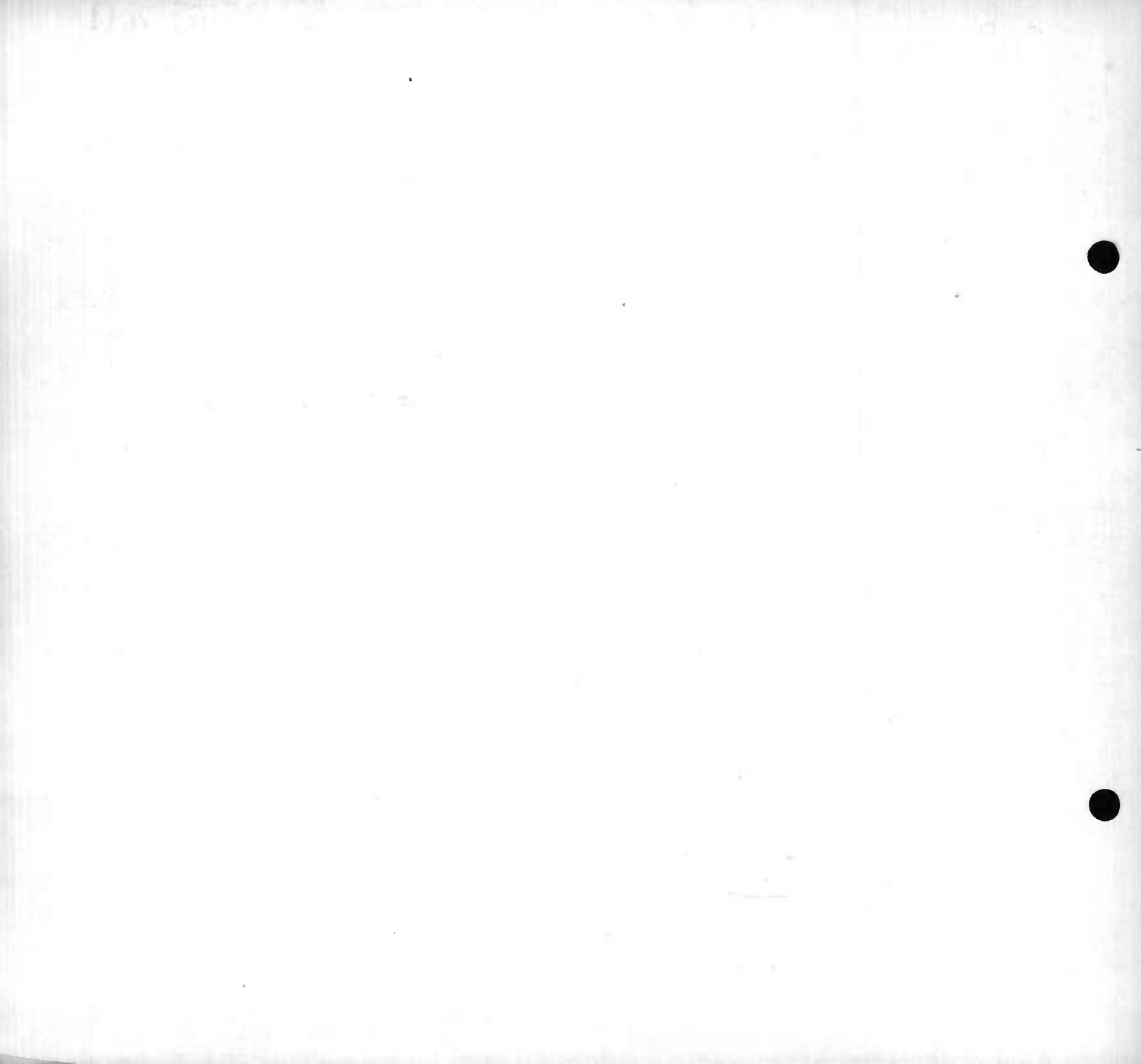
James D. Harris

App. Executive Director

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 7614	
BIRTH NO. 67 7614		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BACKOF Mrs Elizabeth		2. DATE AND HOUR OF DEATH 7:40 pm 8/16/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSPITAL		A. STATE Md B. COUNTY Bt city			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-02			
		D. STREET ADDRESS (If rural, give location) 1536 SHADYSIDE Rd. #18			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-18-10	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY Daniel C. Joseph		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? AMER		13. FATHER'S NAME RICHARD H. CROSS		14. MOTHER'S MAIDEN NAME JULIA BARRETT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-09-1681		17. INFORMANT ADDRESS Gerard Backof, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO METASTATIC CA		INTERVAL BETWEEN ONSET AND DEATH 18 Mo	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/26/67 to 8/16/67 that (I) (we) last saw the deceased alive on 8/16/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I Kiraly		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) LASZLO KIRALY		23D. ADDRESS M.D. 100 N. BROADWAY.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 3331 Brehms Lane #13	



M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROY WISEMAN, JR. 2. DATE AND HOUR PRONOUNCED DEAD August 5, 1967 10:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA_) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2621 E. Madison St. #5

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single 8. DATE OF BIRTH June 14, 1967 9. AGE (In years last birthday) 7 Weeks

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10B. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Roy Wiseman Sr. 14. MOTHER'S MAIDEN NAME Hilda Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT ADDRESS Roy Wiseman Sr., Father, above

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial Pneumonitis DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 219B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) /X Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 8/6/67

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8/8/1967 23C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery Balto., Md. 23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 2601-03-05 E. Madison Street #5

2000 50

class 10

RECEIVED
JAN 10 1900

RECEIVED
JAN 10 1900

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN

Robert

JENKINS Sr.

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967

10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3400 Clifftmont Avenue #13

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 31, 1911

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Real Estate Agent

10B. KIND OF BUSINESS OR INDUSTRY

W. F. Gebhardt

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert E. Jenkins

14. MOTHER'S MAIDEN NAME

Sophia Sulc

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-36-6616

17. INFORMANT

ADDRESS

Robert Jenkins, son, 4523 Marx Avenue #6

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/9/67

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1967

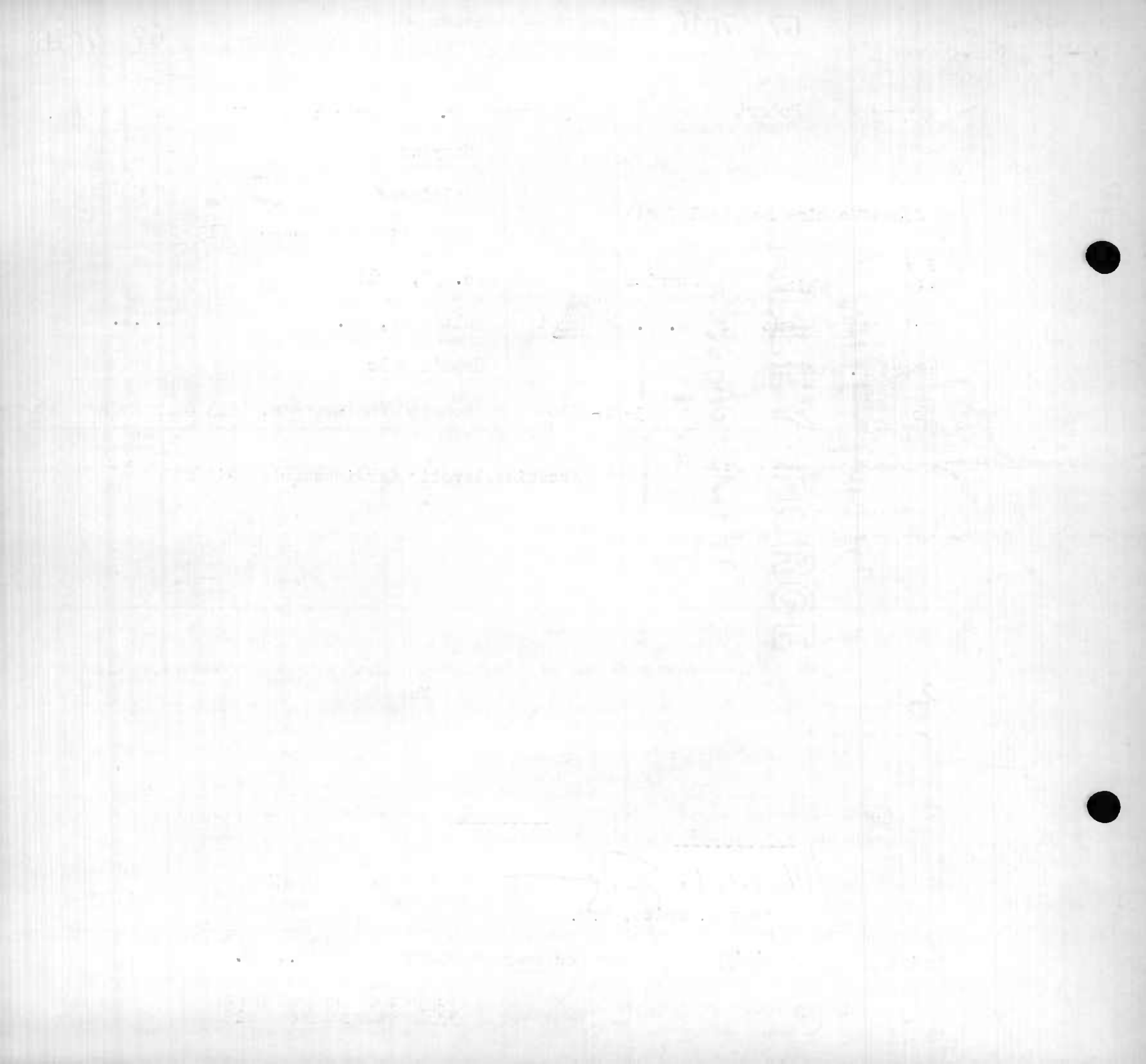
24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Schimunek Funeral Home
3331 Brehms Lane #13

ADDRESS



1
17-630

67 7617

BALTIMORE CITY HEALTH DEPARTMENT

67 7617

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) BARBARA E. HART		2. DATE AND HOUR PRONOUNCED DEAD August 6, 1967 6:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 714 N. Linwood Avenue #5	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 26, 1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 75
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Gross		14. MOTHER'S MAIDEN NAME Catherine Neubert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS George J. Hart, husband, above
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/6/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 8/10/67	23C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	23D. LOCATION (City, town, or county) (State) Balto., Md.
24A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	24C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 2601-03-05 E. Madison Streey #5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7618	
BIRTH NO.		67 7618		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MEYER WILBUR.		2. DATE AND HOUR OF DEATH 8/5/67. 1:15 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3613 - ELM. AVE. #11	
5. SEX MALE	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11/9/14	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 213-16861		17. INFORMANT C. MARIE KOENEKE (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular disease. (B) Myocardial Infarction. (C)		INTERVAL BETWEEN ONSET AND DEATH 8 years 4 hrs 15 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/22/67 to 8/5/67 19 67 and that (I) (we) lost saw the deceased alive on 8/5/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Imtiaz Hamid M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/5/67	
23C. PHYSICIAN'S NAME (Type) IMTIAZ HAMID		23D. ADDRESS M.D. SINAI HOSPITAL. BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/5/67		24C. NAME OF CEMETERY or CREMATORY WOODLAWN	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Ralph J. ...			

1871 June 25th Sunday

1871 June 25th Sunday
St. James Church

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7619	
BIRTH NO. 67 7619		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LUTHER CARSON THORNTON		2. DATE AND HOUR OF DEATH 8/3/67. 2:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE.			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-06			
		D. STREET ADDRESS (If rural, give location) 211 WEST 27th STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/20/89	9. AGE (In years last birthday) 77 years	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME Jim Thornton		14. MOTHER'S MAIDEN NAME SARAH ATWELL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. MCR AB 213-10-1550A		17. INFORMANT MRS EDITH THORNTON	
18. 260X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA		→ 1 week	
ANTECEDENT CAUSES		(B) GANGRENE (TOES)		→ 3 MONTHS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DIABETES		→ unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7/15/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DIABETIC GANGRENE		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1967 to 8/3 1967 , that (I) (we) last saw the deceased alive on 8/3/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE DERMOT CAMPBELL				23B. DATE SIGNED 8/3/67	
23C. PHYSICIAN'S NAME (Type) DERMOT CAMPBELL				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/5/67		24C. NAME OF CEMETERY OR CREMATORY WOODLAWN	
24D. LOCATION (City, town, or county) (State) BALTE. MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Balt. Christian 3617 Chestnut Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7620	
BIRTH NO. 67 7620		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HATTIE ETHELYN NEWTON (Mrs. EDWARD)		AUGUST 5, 1967 13:05 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		A. STATE MARYLAND			
		B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
THE UNION MEMORIAL HOSPITAL 332 + CAIVERT STREET BALTIMORE, MD 21218		BALTIMORE 12-02			
		D. STREET ADDRESS (If rural, give location)			
		3028 GUILFORD AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
FEMALE	CAUCASIAN	WIDOWED	4/10/86	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
UNEMPLOYED				DELAWARE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
KALAB R. CANNON		Missouri Cannon		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		UNKNOWN		FRANK YOUNG	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Cerebrovascular Accident		1 Day	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
Diabetes Mellitus, Arteriosclerosis, Heart Disease					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 26, 1967 to August 5, 1967, that (I) (we) last saw the deceased alive on August 5, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.		23B. DATE SIGNED	
William H. Spencer-Strong				August 5, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLIAM H. SPENCER-STRONG		THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/7/67		Odd Fellow Cem	
				Seaford Del	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1967		Robert E. Jenkins		Lewin R. Wilson	
				Princess Anne	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-520		67. 7621		BALTIMORE CITY HEALTH DEPT.		Registered No. 67 7621	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				THOMAS HENRY LINK		25 JULY 1967 11:50 A.M.	
1. NAME OF DECEASED (Type or Print)		THOMAS HENRY LINK		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 BALTIMORE CITY HOSPITALS		(If not in hospital or institution, give street address or location)		MARYLAND BALTIMORE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		White		MARRIED		2/3/89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
ACETYLENE BURNER		STEEL		78		BALTIMORE MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		17. INFORMANT	
THOMAS HENRY LINK		ELIZABETH BARTONS		USA		RECORDS: Baltimore City Hospitals 14940 Eastern Avenue, Baltimore, Md. 21224	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION		18. CAUSE OF DEATH	
NO		213-03644				INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) BENIGN PROSTATIC HYPERTROPHY 1 YEAR					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO					
ANTECEDENT CAUSES		(C) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (if this hospital) attended the deceased from MAY 8, 1967 to 25 JULY 1967, that (I) last saw the deceased alive on 25 JULY 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Michael R. McMillan M.D.		27 July 1967		MICHAEL R. MCMILLAN		4940 Eastern Ave., Balto, Md. 21224 BALTIMORE CITY HOSPITALS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
8-3-67							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1967		Robert E. Jenkins				UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7622

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

KEESEY

2. DATE AND HOUR PRONOUNCED DEAD

July 18, 1967

7:24 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

605 S. Sharp Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)
605 S. Sharp Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)
60If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/18/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8-8-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

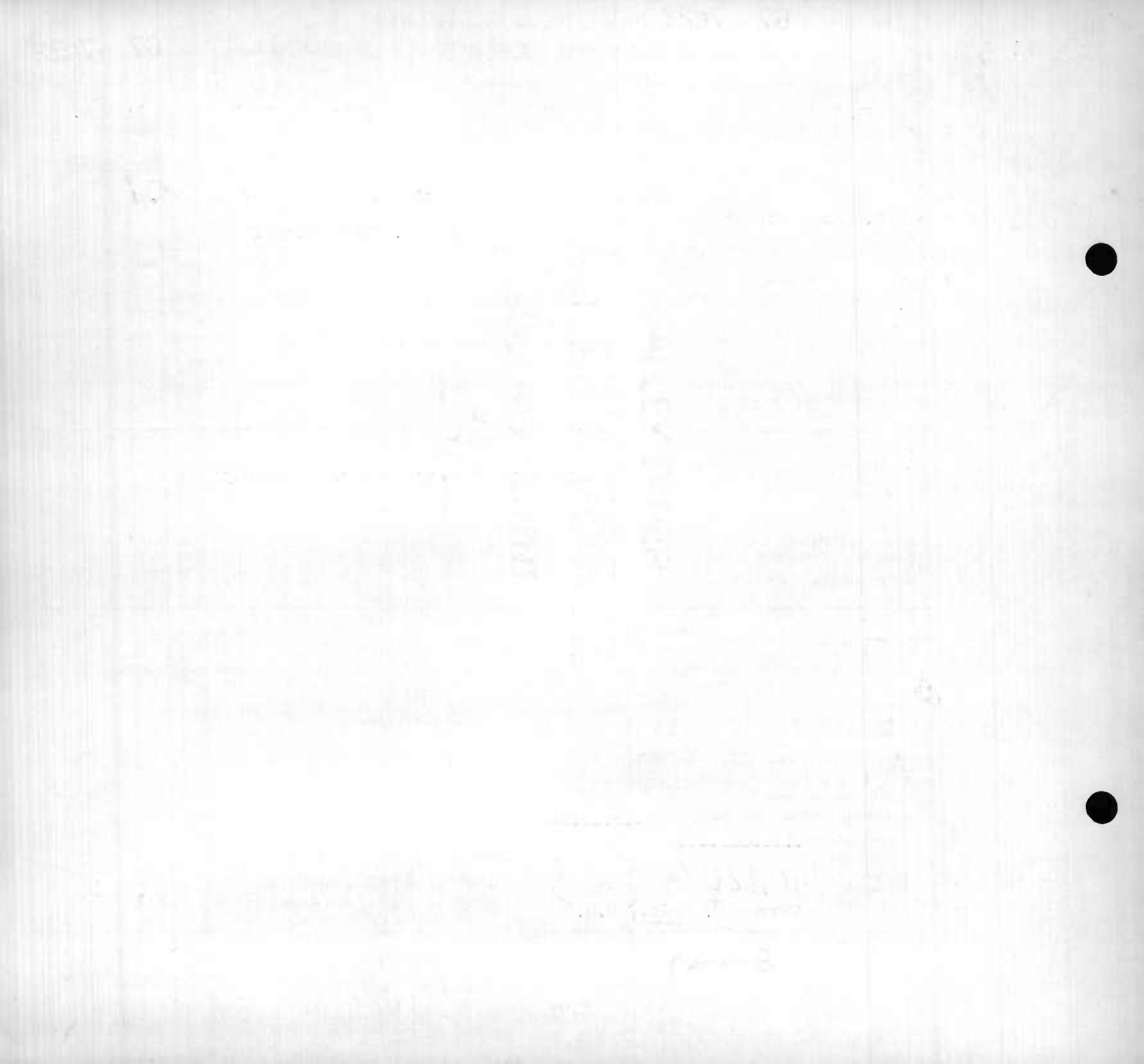
24C. FUNERAL DIRECTOR

ADDRESS

AUG 9 1967

Robert E. Fairley

MORTUARY SERVICE - BCHD



M.E. CASE NO.

1. NAME OF DECEASED

(Type) JOHN

E.

BOOKER

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1967

1:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4 N. Fremont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4 N. Fremont Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/1/1892

9. AGE (In years last birthday)

74

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter (Ret.)

10B. KIND OF BUSINESS OR INDUSTRY

Glass Co.

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Amby Jones

14. MOTHER'S MAIDEN NAME

Irene Booker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-05-6677

17. INFORMANT

Elise D. Booker - 4 N. Fremont Ave

ADDRESS

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

8/8/67

EXAMINER'S NAME (Type)

ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

8/12/67

23C. NAME of CEMETERY or CREMATORY

312 Liberty Baptist

23D. LOCATION

New Canton Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1967

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Furnell S. Oden - Balto. Md.

ADDRESS

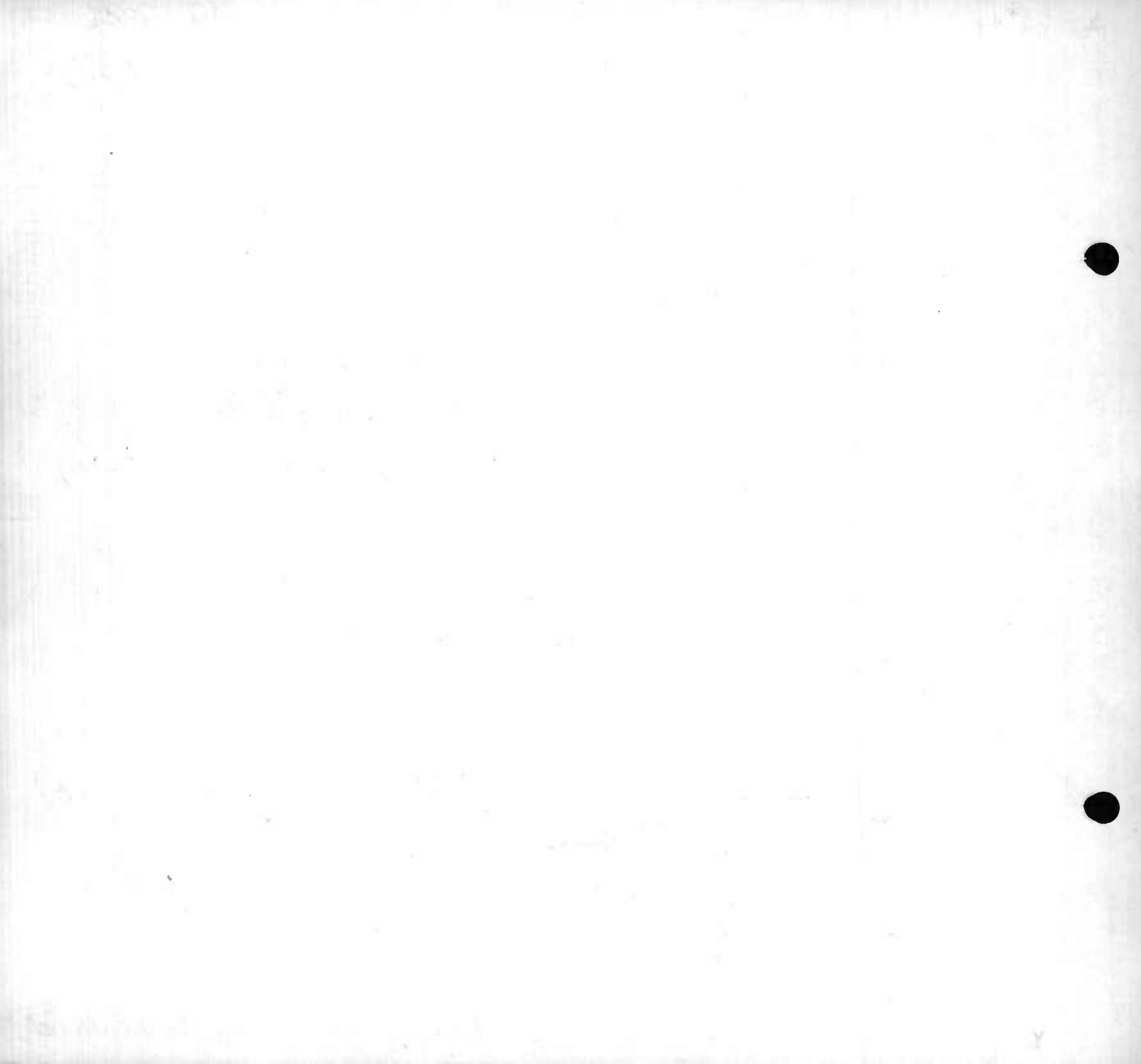
WILLIAM FORGE

1.10.1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7624		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7624	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Bessie A. Arnold</i>		2. DATE AND HOUR OF DEATH <i>Aug 7 1967 12:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Long Green Nursing Home</i> <i>115 E Melrose Ave</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4604 Schenley Rd</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>March 2 1883</i>	9. AGE (In years lost birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Frank Baldwin</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Spriggs</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Maudie A Arnold</i> ADDRESS <i>4604 Schenley Rd</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO <i>Broncho-pneumonia</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Atherosclerosis</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>Aug 5 1967</i> and that (I) (we) last saw the deceased alive on <i>Aug 5 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wm G. Helfrich</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>8/8/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr William G. Helfrich</i>		23D. ADDRESS <i>5006 Roland Ave Balto Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-10-67</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Louden Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Burges Funeral Home</i> ADDRESS <i>3631 Falls Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

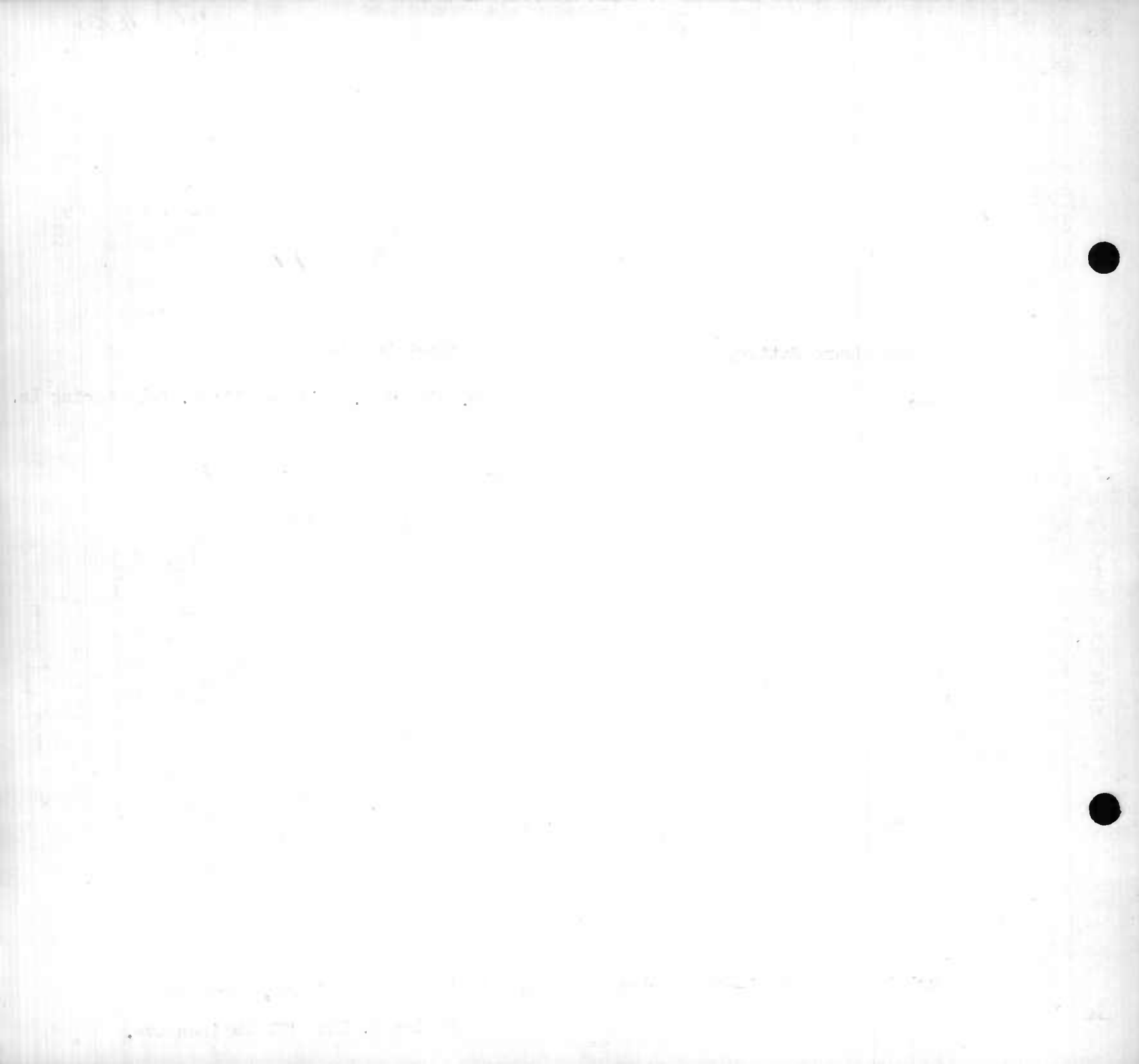
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7625		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7625	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMAS J. SMITH		2. DATE AND HOUR OF DEATH AUG. 7, 1967 6:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
42 SINAI HOSP OF BALTO		D. STREET ADDRESS (If rural, give location)		3307 WINTERBOURNE RD.	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 9/11/82	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARRIER		10B. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Samuel Smith		14. MOTHER'S MAIDEN NAME ANNIE		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-36-1327		17. INFORMANT Stanley M. Smith ADDRESS	
18. 45-0.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) PULMONARY EMBOLISM DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) BRONCHOPNEUMONIA DUE TO			
		(C) GENERALIZED ARTERIOSCLEROSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/7/67 to 8/7/67 and that (2) (we) last saw the deceased alive on 8/7/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward R. Cohen M.D.		23B. DATE SIGNED 8/7/67		23C. PHYSICIAN'S NAME (Type) EDWARD R. COHEN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Charles R. Law		25D. ADDRESS 802 Madison Ave.			

FUNERAL DIRECTOR: IMPORTANT

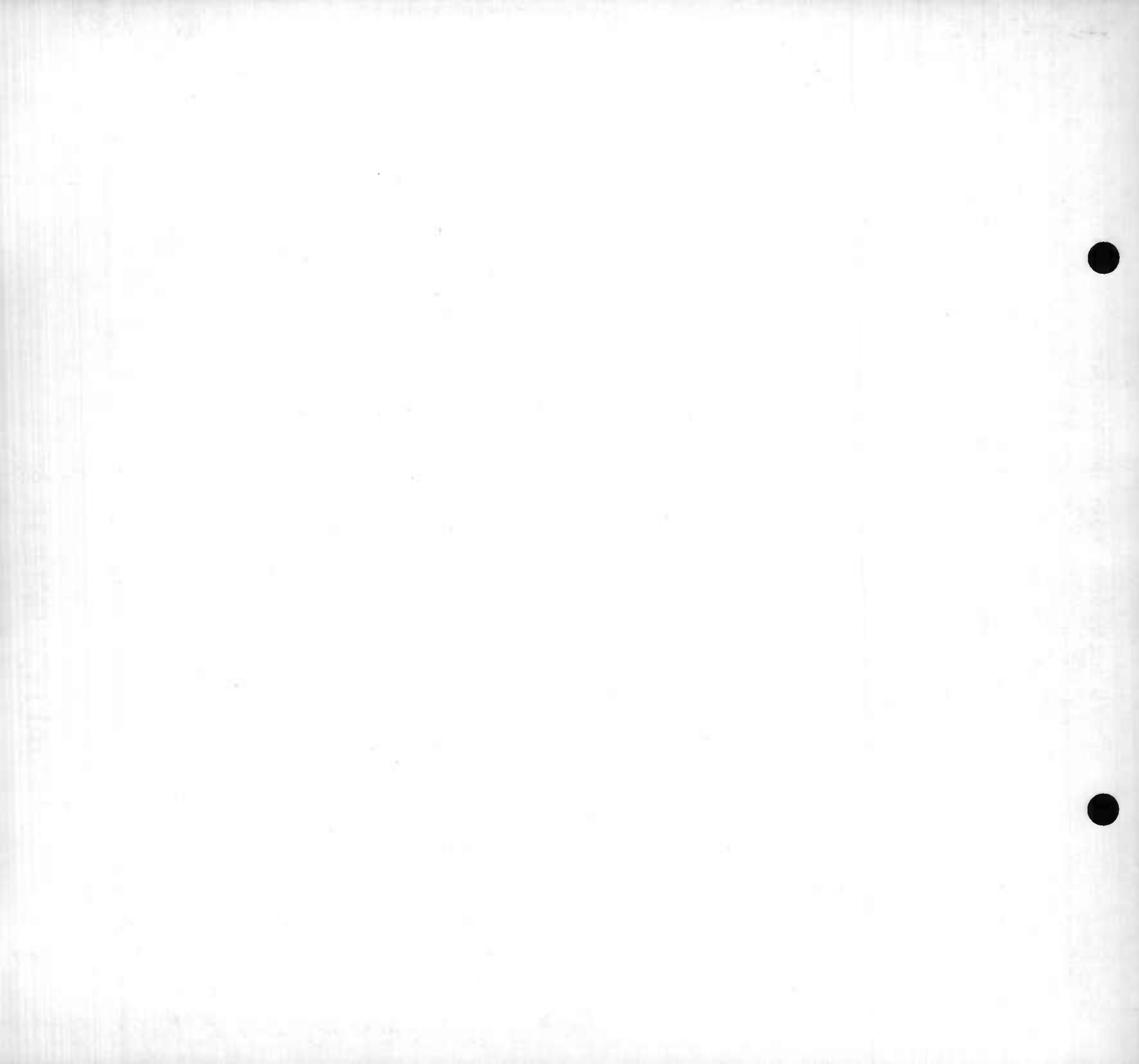
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7626		67 7626	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				SMITH, ANNIE R.		8/7/67 6.40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
SINAL HOSPITAL OF		BALTIMORE		MARYLAND		2114 E. COLD SPRING LANE 14	
42				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 27-03	
				D. STREET ADDRESS (If rural, give location)		2114 E. COLD SPRING LANE 14	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
FEMALE	NEGRO	MARRIED	12/29/95	71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				D.C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Edward Rattley				Sarah Butler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no				Dr. Albert A. Smith - 2114 E. Cold Spring Ln.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) CONGESTIVE HEART FAILURE					
ANTECEDENT CAUSES		(B) CARCINOMA OF PANCREAS					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8/6/67		PYLORIC OBSTRUCTION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/4/1967 to 8/7/1967, that (I) (we) last saw the deceased alive on 8/7/1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
R. Spanos						8/7/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PANAYIOTIS C SPANOS M.D.				SINAL HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-11-67		Arbutus Memorial Park		Baltimore, Maryland	
25A. DATE REC'D BY		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1967		Robert E. Fisher		Charles R. Law		802 Madison Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

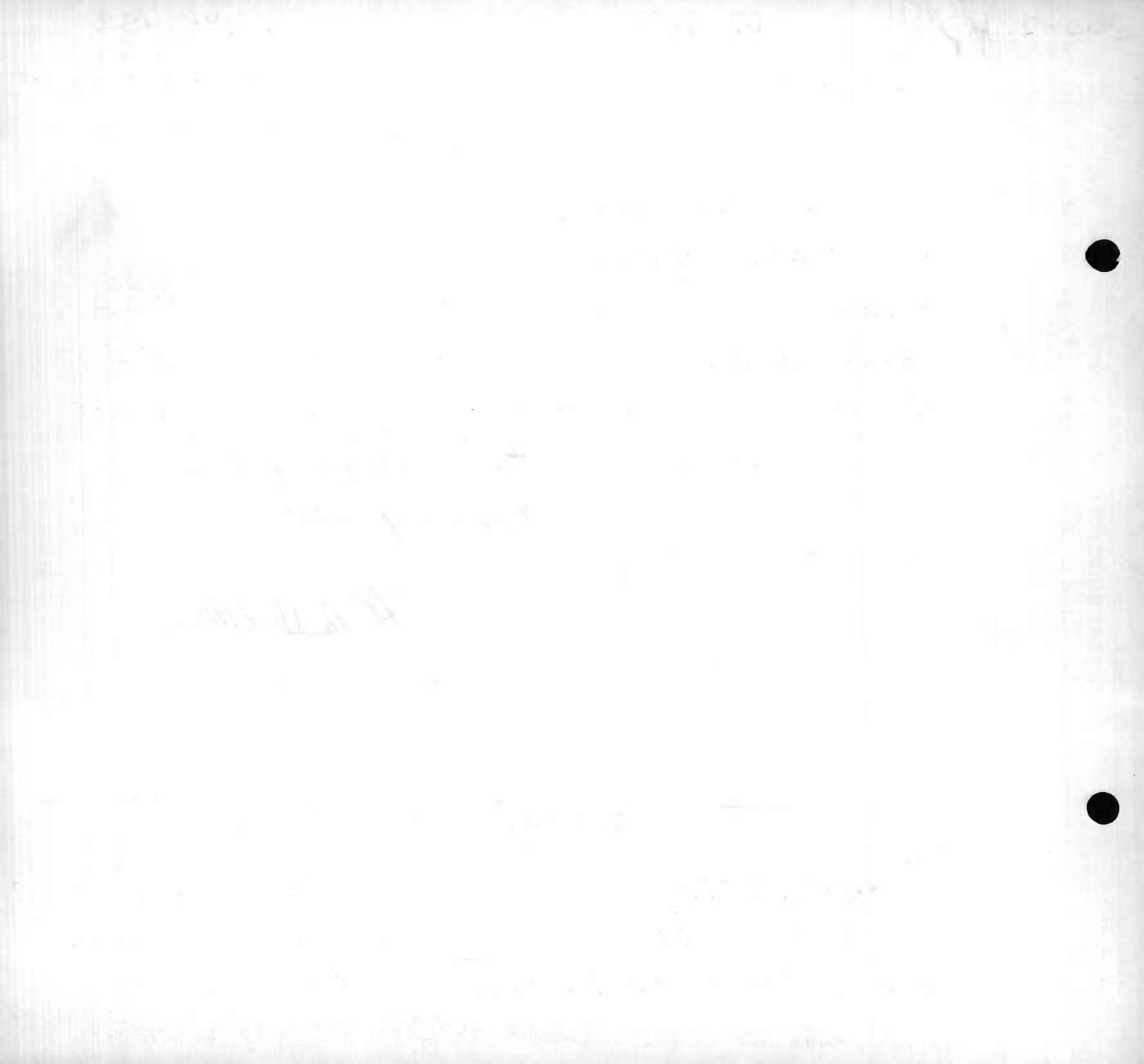
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 67 7628	
1. NAME OF DECEASED (Type or Print) LOUIS C. WESSEL		2. DATE AND HOUR OF DEATH 7 August 1967 7:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND - BALTIMORE CO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON 53-00 D. STREET ADDRESS (If rural, give location) 221 BOSLEY AVENUE			
5. SEX MALE	6. RACE CAU.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-15-88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLER		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY WESSEL			
14. MOTHER'S MAIDEN NAME IDA — (UNKNOWN)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 219-16-5331		17. INFORMANT ADDRESS HOSPITAL ADMISSION HISTORY			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 710X I CAUSE OF DEATH - Congestive Heart Failure - Extensor and Insufficiency of aortic valve Insufficiency of mitral valve		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 22 JULY 1967 to 7 AUGUST 1967 , that (I) (we) last saw the deceased alive on 7 AUGUST 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. E. Cathey		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7 AUGUST 1967	
23C. PHYSICIAN'S NAME (Type) B. E. CATHEY		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-10-67		24C. NAME OF CEMETERY or CREMATORY London PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967			
25B. NAME OF REGISTRAR Wm E. Fairbank		25C. FUNERAL DIRECTOR Wm Cook - Brooks Towson			
25D. ADDRESS 1050 York Rd Towson Md		25E. 2/20/67			



R. 200

67 07629

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 07629

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) FRED RICE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 8 Day 4 Year 67 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		3. DATE PRONOUNCED DEAD Month August Day 4 Year 1967 M.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Prince Frederick	
9. DATE OF BIRTH Jan 7, 1912		10. AGE (in years lost birthday) 55	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Pulmonary embolus	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) Fracture of cervical and thoracic vertebral column with paraplegia			
		(C)			

20A. DATE OF OPERATION 8/1/67		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractures of vertebral column		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Factory		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ?	
22D. TIME OF INJURY (APPROX.) 7 31 67 ?		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell from building	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE Edward F. Wilson		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

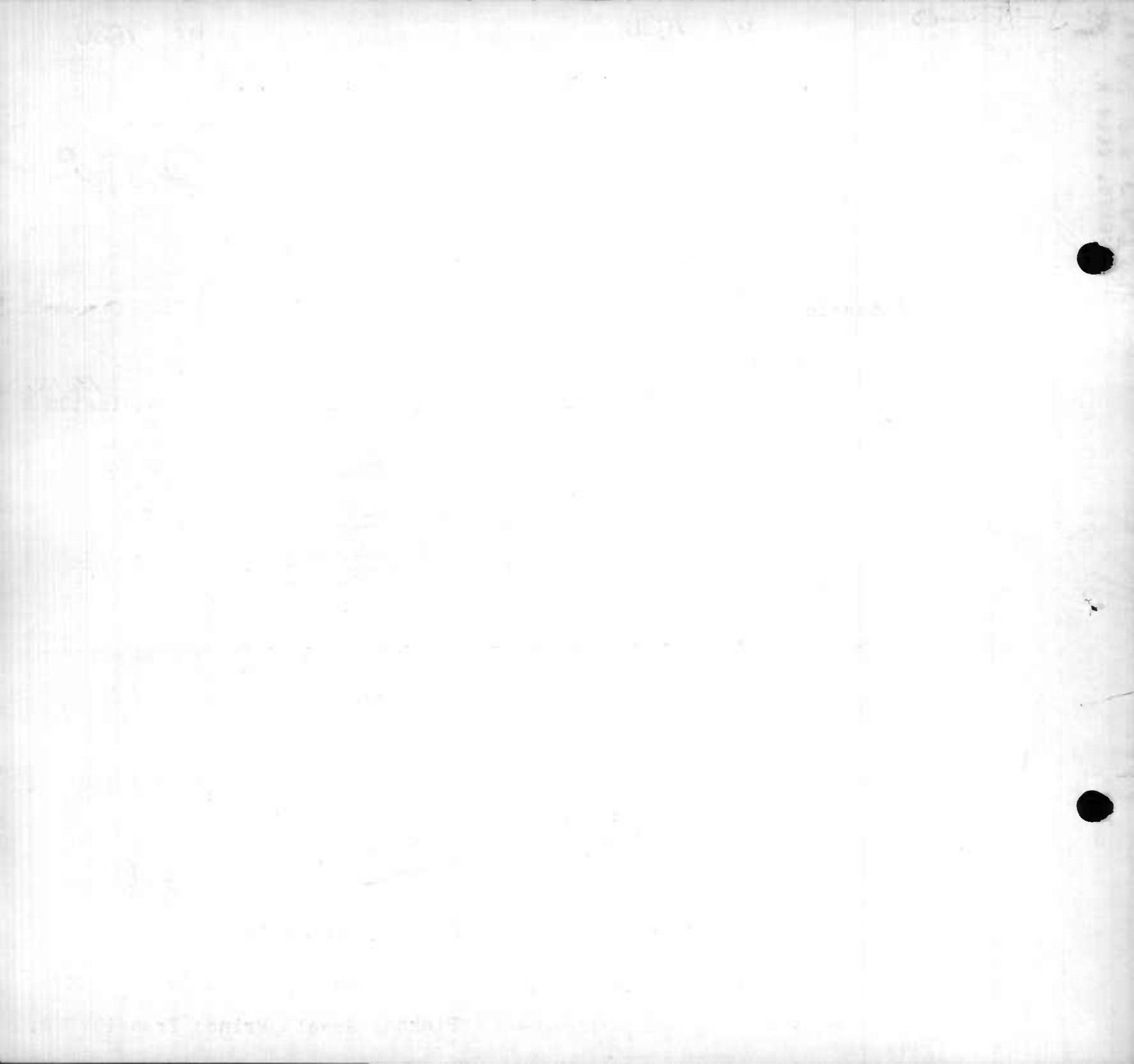
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE AUG 9 1967		24C. NAME OF CEMETERY or CREMATORY Prince Frederick, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Pinkney E. Sewell, Prince Frederick Maryland	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7630		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7630	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) JONES, ELLA MAE			2. DATE AND HOUR OF DEATH 2:45 AM 8,3,67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1308 SHELLBANKS ROAD 21225		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-7-21	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME JOSEPH GARDNER		
14. MOTHER'S MAIDEN NAME EDITH FISHER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 219-16-7282			17. INFORMANT Pinkney Garner 1211 Woodington R		
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) HYPOVOLEMIC SHOCK DUE TO (B) ACUTE GI HEMORRHAGE DUE TO (C) METASTATIC CARCINOMA OF BREAST INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 days 2 years			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11:45 PM 8/2/67 to 2:45 AM 8/3/67 and that (1) (we) last saw the deceased alive on 2:45 AM 8/3/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen B. Kaiser				23B. DATE SIGNED 8/3/67	
23C. PHYSICIAN'S NAME (Type) Allen B. Kaiser				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) 8-6-67		24B. DATE St. John Ch. Cem		24C. NAME OF CEMETERY or CREMATORY Lusby, Calvert Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Pinkney Sewell Prince Fredrick Md.			



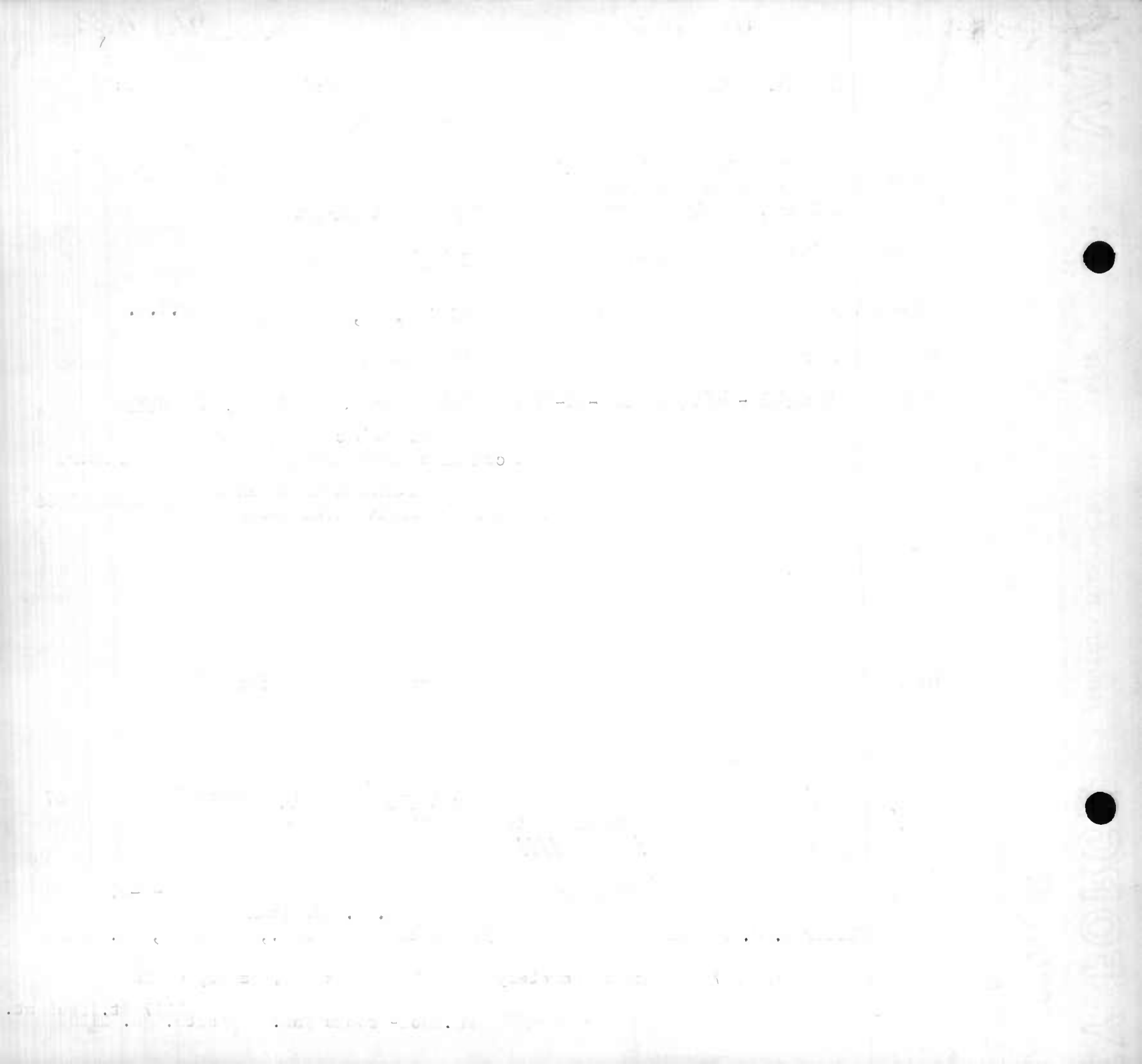
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7631	
BIRTH NO. 67 7631		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DIXON, MAUDE G.		2. DATE AND HOUR OF DEATH August 7, 1967 10:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION 90 Gould Convalesarium		A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1508 Gorsuch Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/15/1880	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel S. Green		14. MOTHER'S MAIDEN NAME Ida E. McDonald	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS William B. Dixon, (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Several years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1959 to August 1967 , that (I) (we) last saw the deceased alive on August 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman M.D.				23B. DATE SIGNED Aug. 7, 67	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.				23D. ADDRESS 3202 Harford Rd Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/1967		24C. NAME OF CEMETERY or CREMATORY Greenmount	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7632		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7632	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HUNTER, Paul B			2. DATE AND HOUR OF DEATH 8/7/67 8:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Oxford D. STREET ADDRESS (If rural, give location) 326 Market Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/31/18	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Rising Sun, Maryland	
13. FATHER'S NAME Joseph Hunter			14. MOTHER'S MAIDEN NAME Mary Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes 5/11/43 - 4/19/46		16. SOCIAL SECURITY NO. 185-01-7737		17. INFORMANT VAH Records, Baltimore, Md ADDRESS 21218	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic erosion of left common carotid artery ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Squamous cell carcinoma of anterior gingiva (resected)			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 Hours December 1966
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 7th 19 67 to August 7th 19 67 , that (I) (we) last saw the deceased alive on August 7th 19 67 and that In (me) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor V. J. Borges M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8-8-67	
23C. PHYSICIAN'S NAME (Type) Victor V. J. Borges		23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/67		24C. NAME OF CEMETERY or CREMATORY Oxford Cemetery	
				24D. LOCATION (City, town, or county) (State) Oxford, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. ADDRESS 1217 St. Paul st. Balto. Md. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7633		Registered No. 67 7633	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Sister Mary Sanctina Wenner				2. DATE AND HOUR OF DEATH 8/8/67 6:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 94 College of Notre Dame Charles Street & Homeland Ave.				A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) Charles Street & Homeland Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH May 17, 1878	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10B. KIND OF BUSINESS OR INDUSTRY College of Notre Dame		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Wenner				14. MOTHER'S MAIDEN NAME Anna Gradl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-54-1103j1		17. INFORMANT ADDRESS Sister Rosita Charles St. & Homeland Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 333 X Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral arteriosclerosis 10 yrs Generalized arteriosclerosis				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1967 to August 8 1967 , that (I) (we) last saw the deceased alive on July 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles J. Blazek M.D.				23B. DATE SIGNED 8/8/67		23C. PHYSICIAN'S NAME (Type) Dr. Charles J. Blazek M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-67		24C. NAME OF CEMETERY or CREMATORY Convent Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore (College of Notre Dame)	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Farber, MA		25C. FUNERAL DIRECTOR ADDRESS Raymond J. Curran 817 Scarlett Dr. 21204			

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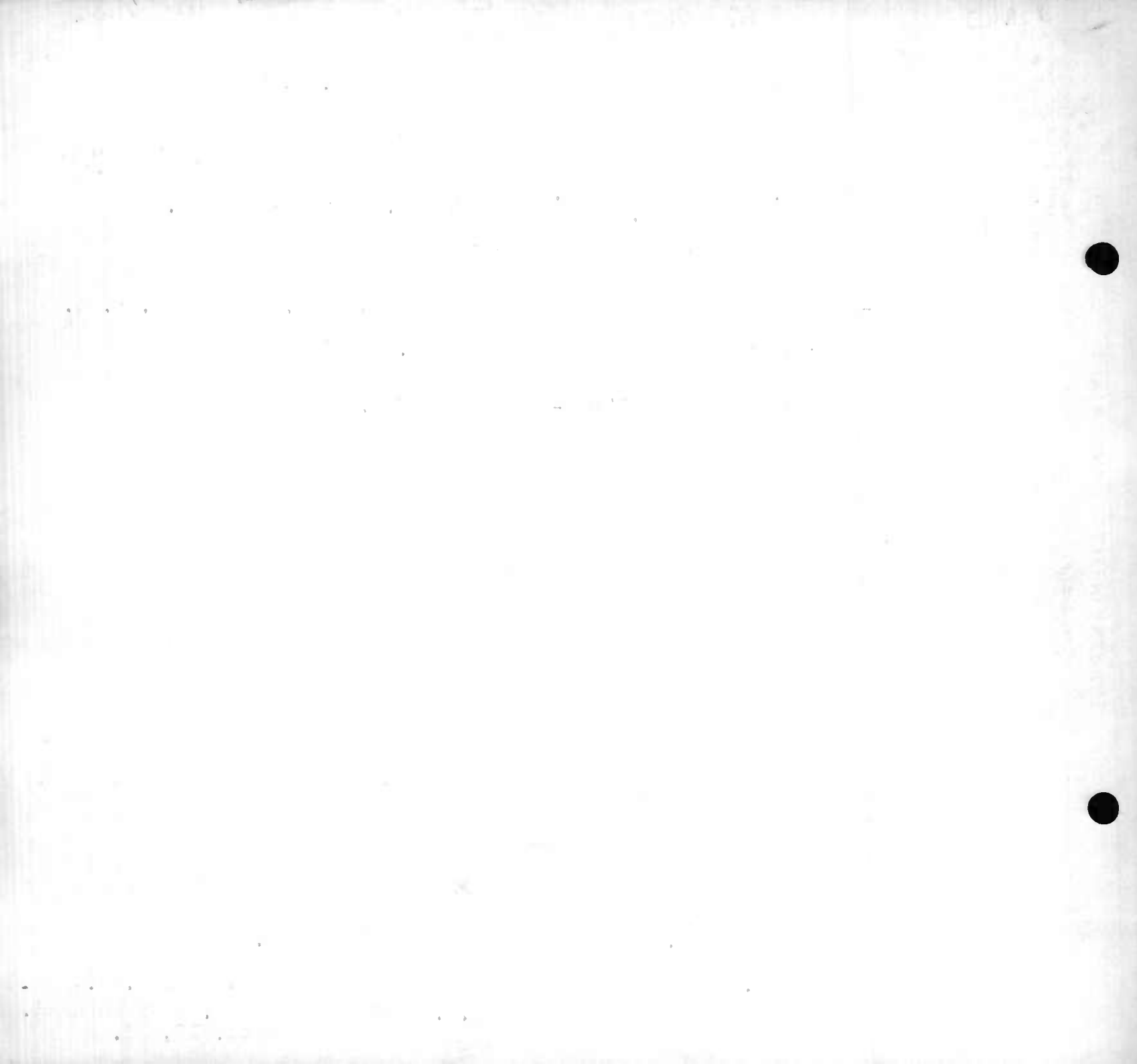
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 7634		67 7634	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Allen Schwarz		Aug. 7, 1967		8:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 100 W. University Pkwy. APT. 8c		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 100 W. University Pkwy.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 1/26/1880	9. AGE (In years lost birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Broker
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Schwarz	
14. MOTHER'S MAIDEN NAME Mary E. Sheeler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-4877	
17. INFORMANT William B. Macomber		18. ADDRESS (Same)		19. CAUSE OF DEATH Coronary Occlusion	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. INTERVAL BETWEEN ONSET AND DEATH		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis	
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE W. G. Helfrich M.D. 23B. DATE SIGNED August 9, 1967		23C. PHYSICIAN'S NAME (Type) William G. Helfrich M.D. 23D. ADDRESS 5006 Roland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

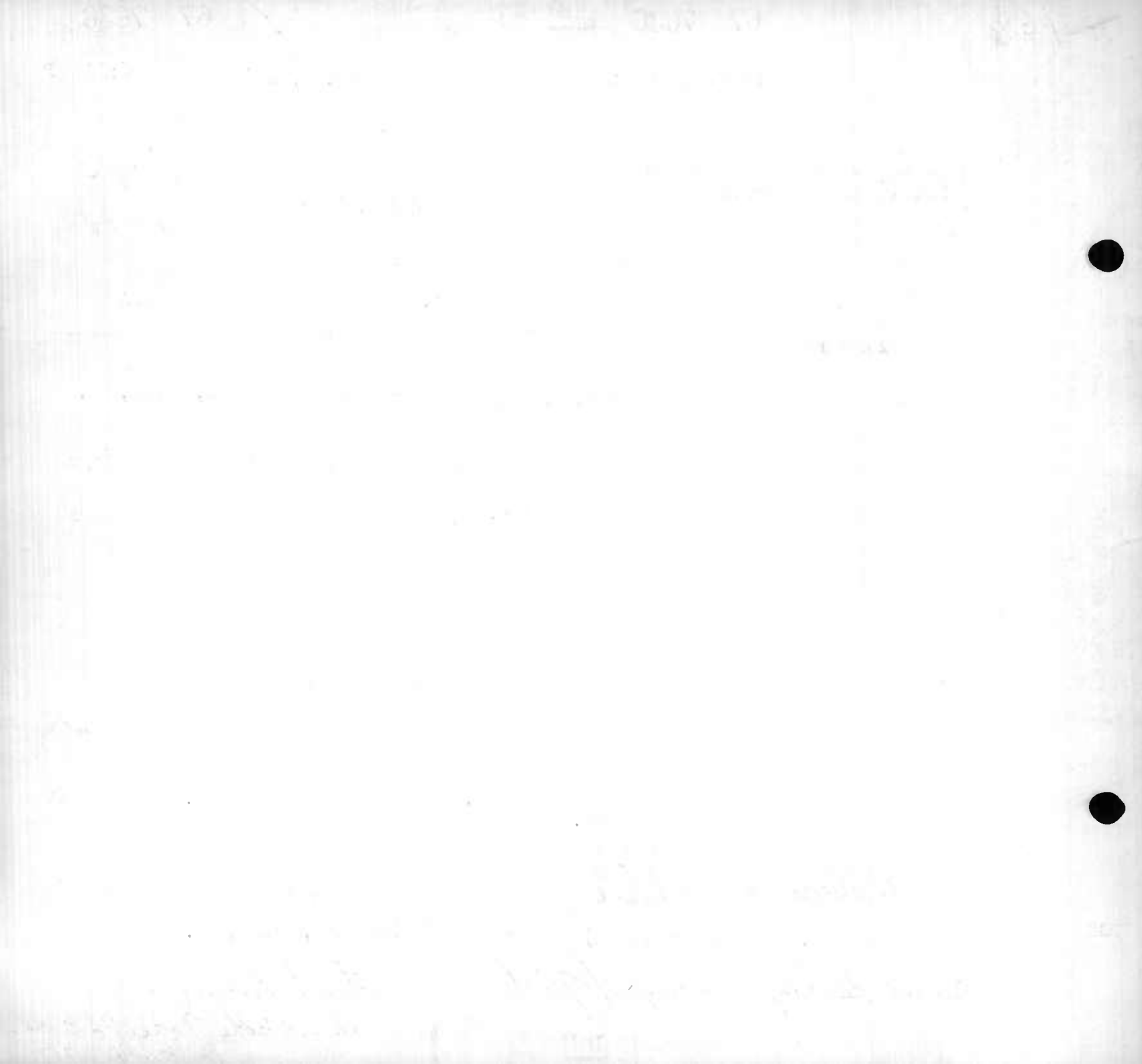
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7635	
BIRTH NO. 67 7635		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOYCE H. STERLING			2. DATE AND HOUR OF DEATH August 5 1967 6:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 38 (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, with RURAL and give township) Baltimore 27-38		
			D. STREET ADDRESS (If rural, give location) 1107 Ramblewood Rd. Apt A		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 1/31/09	9. AGE (In years lost birthday) 58	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superwoman in Hutyless Department			10B. KIND OF BUSINESS OR INDUSTRY CRISFIELD, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Franklin Sterling			14. MOTHER'S MAIDEN NAME Eva Moore		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 085-09-3373		
			17. INFORMANT ADDRESS (Chart) CHARLES H. STERLING (SAME)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I			CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) _____ DUE TO (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 1 day		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-5 19 67 to 8-5 19 67 , that (I) (we) last saw the deceased alive on 8-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. A. Portnoy				23B. DATE SIGNED 8-5-67	
23C. PHYSICIAN'S NAME (Type) B. A. Portnoy				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/1967		24C. NAME of CEMETERY or CREMATORY Sunny Ridge	
24D. LOCATION Crisfield, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1967			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

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Handwritten text, possibly a date or number, appearing below the first line of text.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7636		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7636	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Laura Elizabeth Haffer			2. DATE AND HOUR OF DEATH Aug. 7, 1967		6:38 P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive			A. STATE Va. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Front Royal		
			D. STREET ADDRESS (If rural, give location) 404 W. 15th Street		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6/21/43	9. AGE (In years lost birthday) 24	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carl Haffer			14. MOTHER'S MAIDEN NAME Helen Curl		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 223-62-5591	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute intraventricular cerebral hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myelogenous leukemia			INTERVAL BETWEEN ONSET AND DEATH Days Weeks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 7, 1967 to Aug. 7, 1967, that (I) (we) last saw the deceased alive on Aug. 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Wilkie M.D.				23B. DATE SIGNED 8/8/67	
23C. PHYSICIAN'S NAME (Type) William L. Wilkie, Surgeon (R) M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. AUG 9 1967		24F. NAME OF REGISTRAR Robert E. Faulkner	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR Wm. J. Tichner & Sons	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR ADDRESS Front Royal VA. Balto., MD 21217	



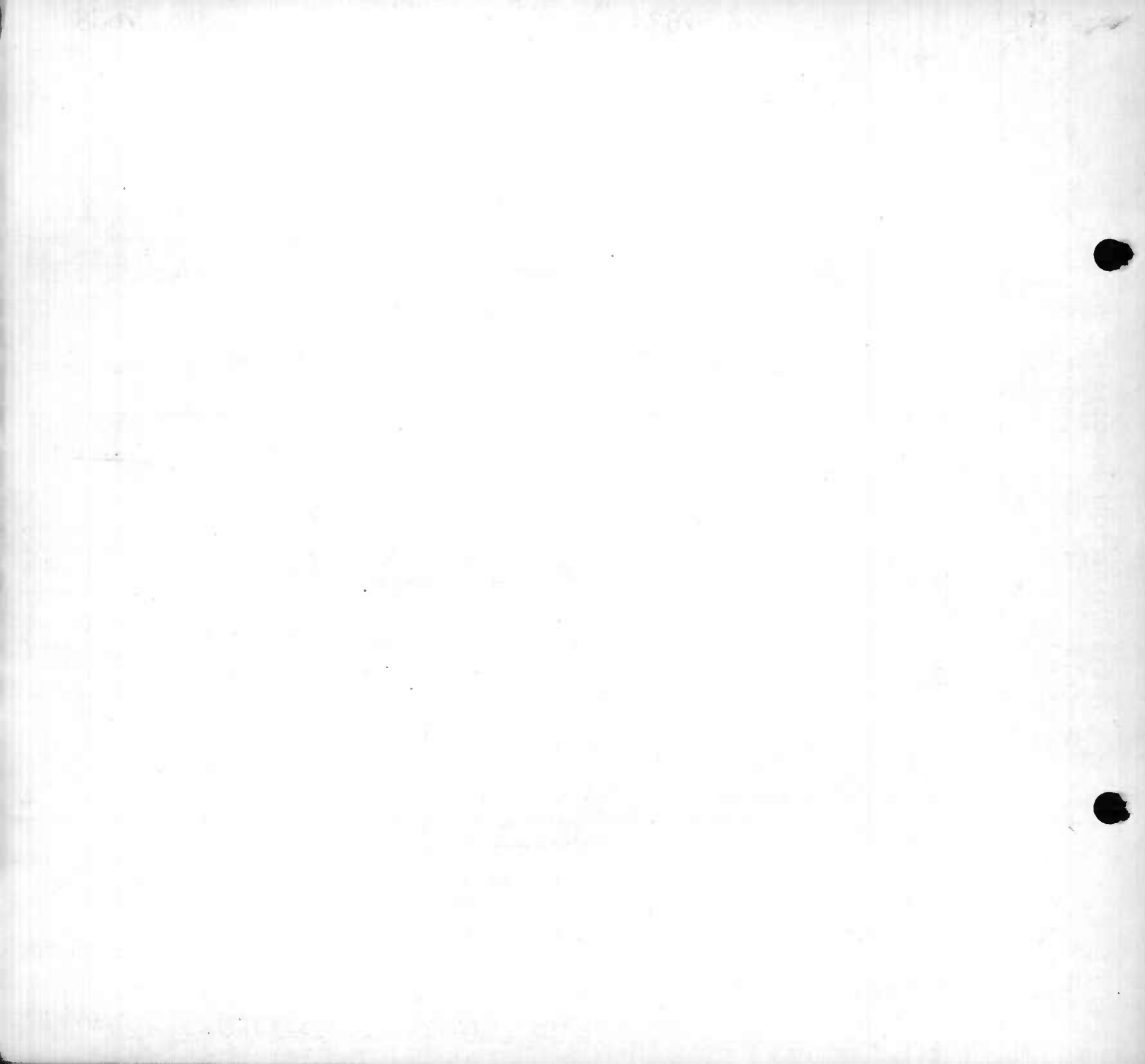
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7637	
BIRTH NO. 67 7637		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ruth Shlian</i>		2. DATE AND HOUR OF DEATH <i>August 6, 1967 5⁰⁰ p.m.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3508 Langrehr Rd., Apt 14</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11-7-19</i>	9. AGE (In years last birthday) <i>47</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JOSEPH MILNOVSKY</i>		14. MOTHER'S MAIDEN NAME <i>EDITH LIEBEROTSKY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>Mrs. Edith Feldman, 6723 Townbrook Drive Apt F #1</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) <i>Breast Carcinoma</i> (B) (C) INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 8 mo.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Dec, 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Right breast carcinoma</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>July 25</i> 19 <i>67</i> to <i>August 6</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>August 6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <i>Coy Freeman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-6-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>COY FREEMAN</i>		23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/8/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Liberty Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Randallstown, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

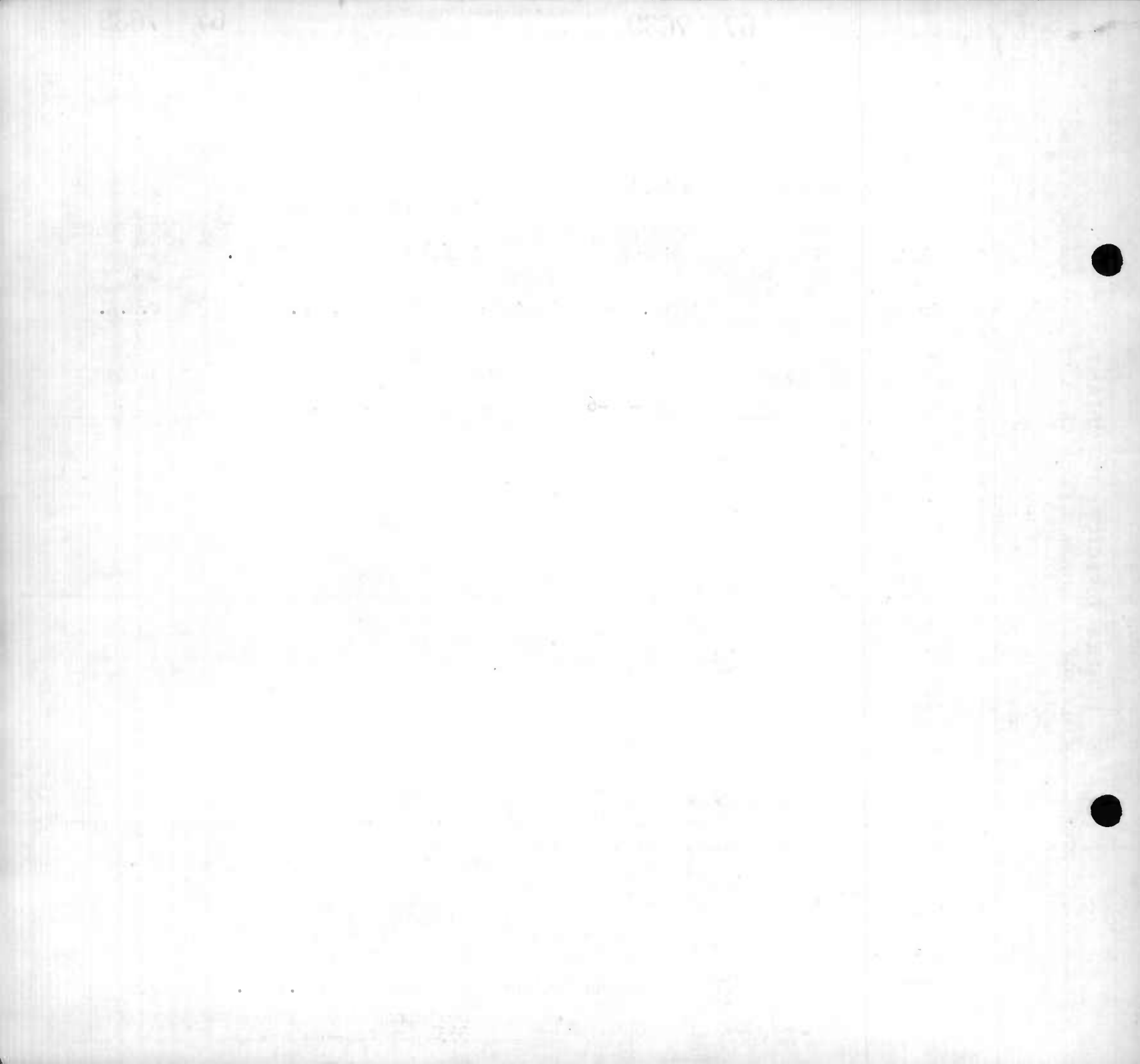
BIRTH NO. <u>67-15252</u> <u>67</u> <u>7638</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>7638</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>SNYDER, BABY GIRL</u>			2. DATE AND HOUR OF DEATH <u>Aug 7, 67</u> <u>12¹⁰</u> <u>p.m.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Highlands</u>		
			D. STREET ADDRESS (If rural, give location) <u>2634 Virginia Ave.</u> <u>53-00</u>		
5. SEX <u>♀</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8/6/67</u>	9. AGE (In years last birthday) <u>-</u>	If Under 1 Yr. Months: <u>1</u> Days: <u>1</u> Hours: <u>-</u> Min: <u>-</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>UNION MEMORIAL HOSP</u>	
13. FATHER'S NAME <u>MR. LORAIN R SNYDER</u>			14. MOTHER'S MAIDEN NAME <u>Dorothy Schiavazzo</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>echo</u>	
18. <u>7638</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Prematurity - 1960 gms</u> (A) <u>Respiratory arrest</u> DUE TO (B) <u>Prematurity & Respiratory</u> DUE TO (C) <u>Asphyxia</u> <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>since birth</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pulmonary consolidation in pneumonia</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 6</u> <u>19 67</u> to <u>Aug 7</u> <u>19 67</u> , that (I) (we) last saw the deceased alive on <u>Aug 7</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Tawee Lin</u>				23B. DATE SIGNED <u>Aug 7, 67</u>	
23C. PHYSICIAN'S NAME (Type) <u>TAWEE LIN M.D.</u>				23D. ADDRESS <u>UNION MEMORIAL HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/9/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Dorsey Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Amber Dr. 1328 Sulphur Dr. Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7639				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7639	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Frank J. Nickel</u>				2. DATE AND HOUR OF DEATH <u>Aug. 8, 1967</u> <u>12:30 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>3000 McElderry Street #5</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u>	8. DATE OF BIRTH <u>3/28/85</u>	9. AGE (In years lost birthday) <u>82 yrs.</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Gas & Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Nickel</u>				14. MOTHER'S MAIDEN NAME <u>Frances Kounrad</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-6104</u>		17. INFORMANT <u>John Nickel, son, above</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>422.1 I Arteriosclerotic Cardiovascular Disease</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>Chronic Nephritis</u>		<u>2 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19 62</u> to <u>August 8 19 67</u> , that (I) (we) last saw the deceased alive on <u>August 6 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Loy M. Zimmerman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Aug. 8, 67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman</u>				23D. ADDRESS <u>3202 Hartford Rd. Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/11/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bohemian National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u>		ADDRESS <u>3331 Brems Lane #13</u>	



m-2551

67 7640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 7640

BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) DUNCAN MACKINNON				8/9/67 1:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33		A. STATE Maryland			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1510 N. Gay St. #13			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-8-12	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs, cashier recently		10B. KIND OF BUSINESS OR INDUSTRY Mid City Garage		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Duncan MacKinnon			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 312-07-0717		17. INFORMANT Marietta C. MacKinnon, wife, above
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Acute Inferior Myocardial Infarct 53 day		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Coronary artery disease			
		(B) DUE TO Generalized arteriosclerosis			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonitis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 1 19 67 to Aug 9 19 67 , that (I) (we) last saw the deceased alive on Aug. 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen B. Kaiser		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) Allen B. Kaiser		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR, ADDRESS Schimunek Funeral Home 3331 Brehms Lane #13	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8/2/07

Chas. B. Jones

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

SAXON, DONALD L.

2. DATE AND HOUR OF DEATH

8/7/67

11:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1027 Spangler Way

21205

5. SEX

MALE

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-18-29

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pipe Fitter

10B. KIND OF BUSINESS OR INDUSTRY

Balto., City

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter Saxon

14. MOTHER'S MAIDEN NAME

Cora Pittman

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Navy

16. SOCIAL
SECURITY NO.

238-34-6262

17. INFORMANT Elaine Saxon, wife, above ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A) DUE TO

Pseudomonas pneumonia

(B) DUE TO

Aspiration, complicating

(C) DUE TO

Anaphylactic reaction to

blood transfusion for GI

Bleed.

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.FATTY ALTERATION OF LIVER.
Alcoholic cirrhosis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)☐21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/1 19 67 to 8/7 19 67.
that (I) (we) last saw the deceased alive on 8/7/67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Zachary Grossman

M.D. Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/7/67

23C. PHYSICIAN'S
NAME (Type)

Zachary Grossman

23D. ADDRESS

M.D.

5964 E. Pratt St.

Baltimore, Md.

21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/8/67

24C. NAME OF CEMETERY or CREMATORY

Holly Hill Mem. Gardens

24D. LOCATION

(City, town, or county)

Balto. County, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1967

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

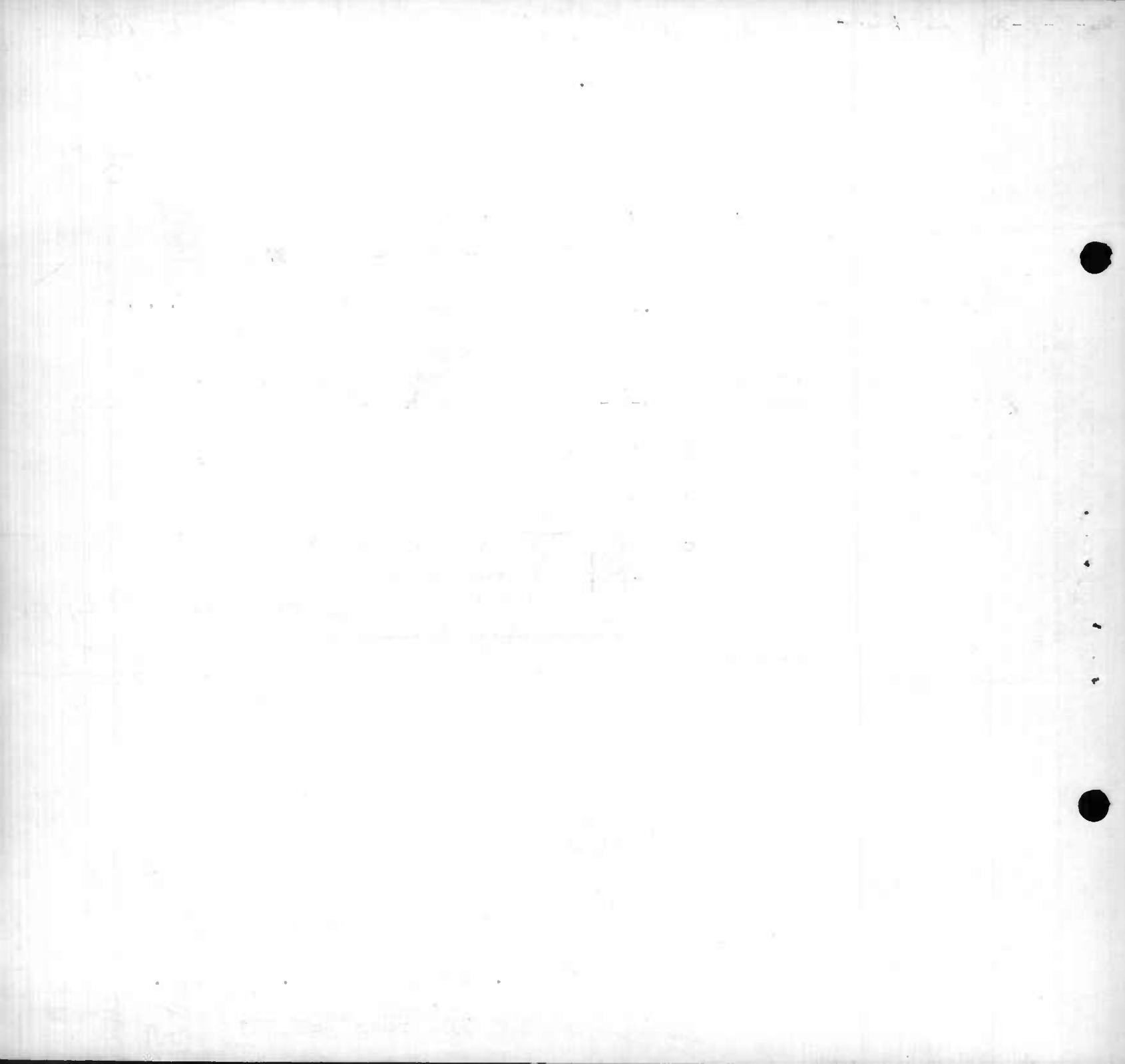
25C. FUNERAL DIRECTOR

Schimunek Funeral Home
3331 Brehms Lane #13

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

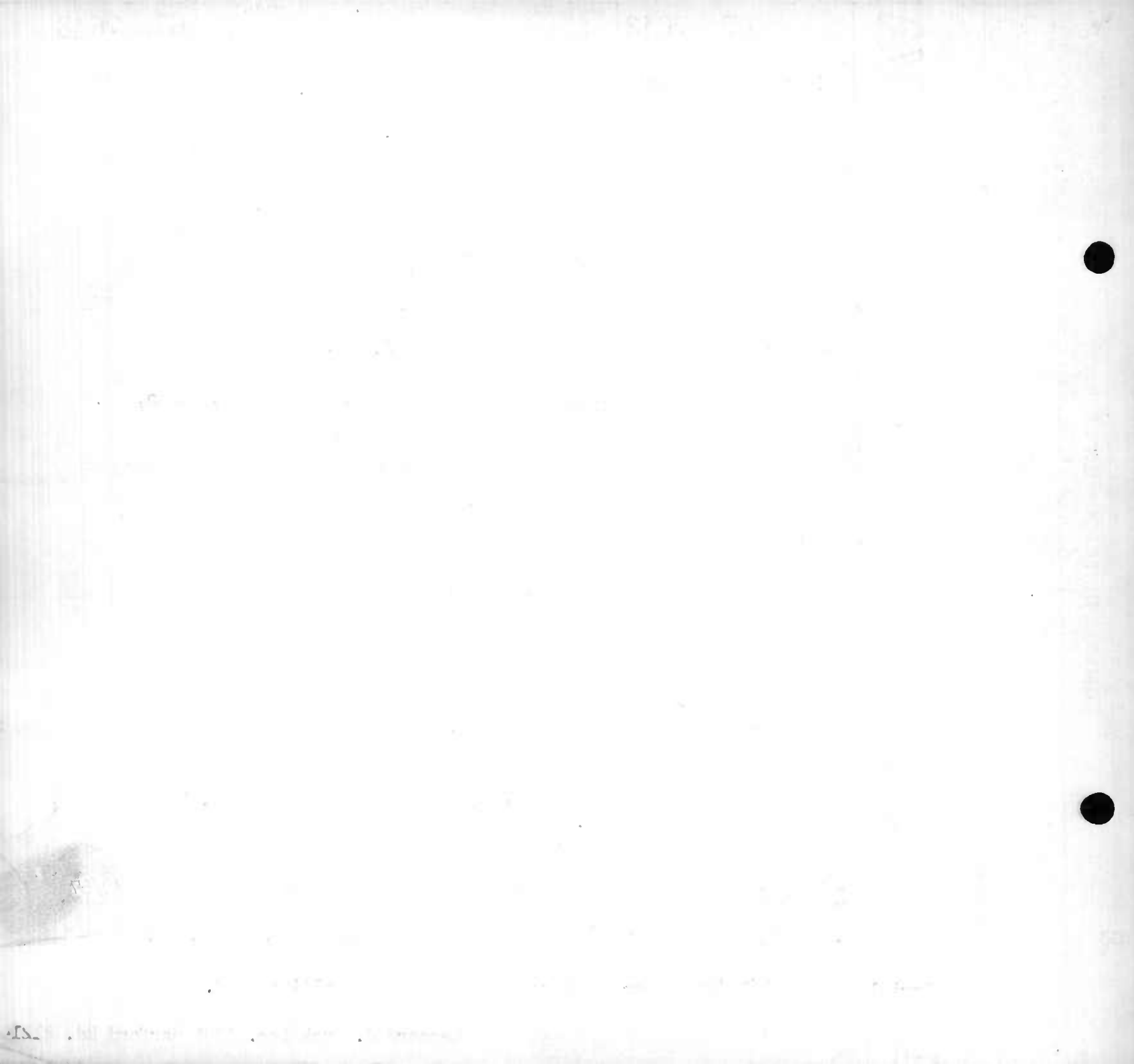
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7642	
BIRTH NO. 67 7642		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dollette Walsh		2. DATE AND HOUR OF DEATH Aug. 8, 1967 10:22 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital		D. STREET ADDRESS (If rural, give location) 641 BARTLETT AVE. #18		9-08	
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 9-11-1890	9. AGE (In years lost birthdate) 75	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co.		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JULIUS WESS		14. MOTHER'S MAIDEN NAME MARY BURNS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-01-6628 A		17. INFORMANT sister MARY KELLY ADDRESS 641 BARTLETT AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA		CAUSE OF DEATH (A) ACUTE PULMONARY EDEMA DUE TO (B) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 50 min.	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 9:30 A.M.	
22. I certify that (I) (this hospital) attended the deceased from August 8 19 67 to Aug. 8 (10:20) 19 67 A.M. that (I) (we) last saw the deceased alive on August 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Z. Vergara M.D.				23B. DATE SIGNED Aug 8, 1967	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA		23D. ADDRESS M.D. CHURCH HOME HOSPITAL 100 N. BROADWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/11/67	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Isley, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13 ADDRESS	

General Instructions

Form 100-10-11-1890 7

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

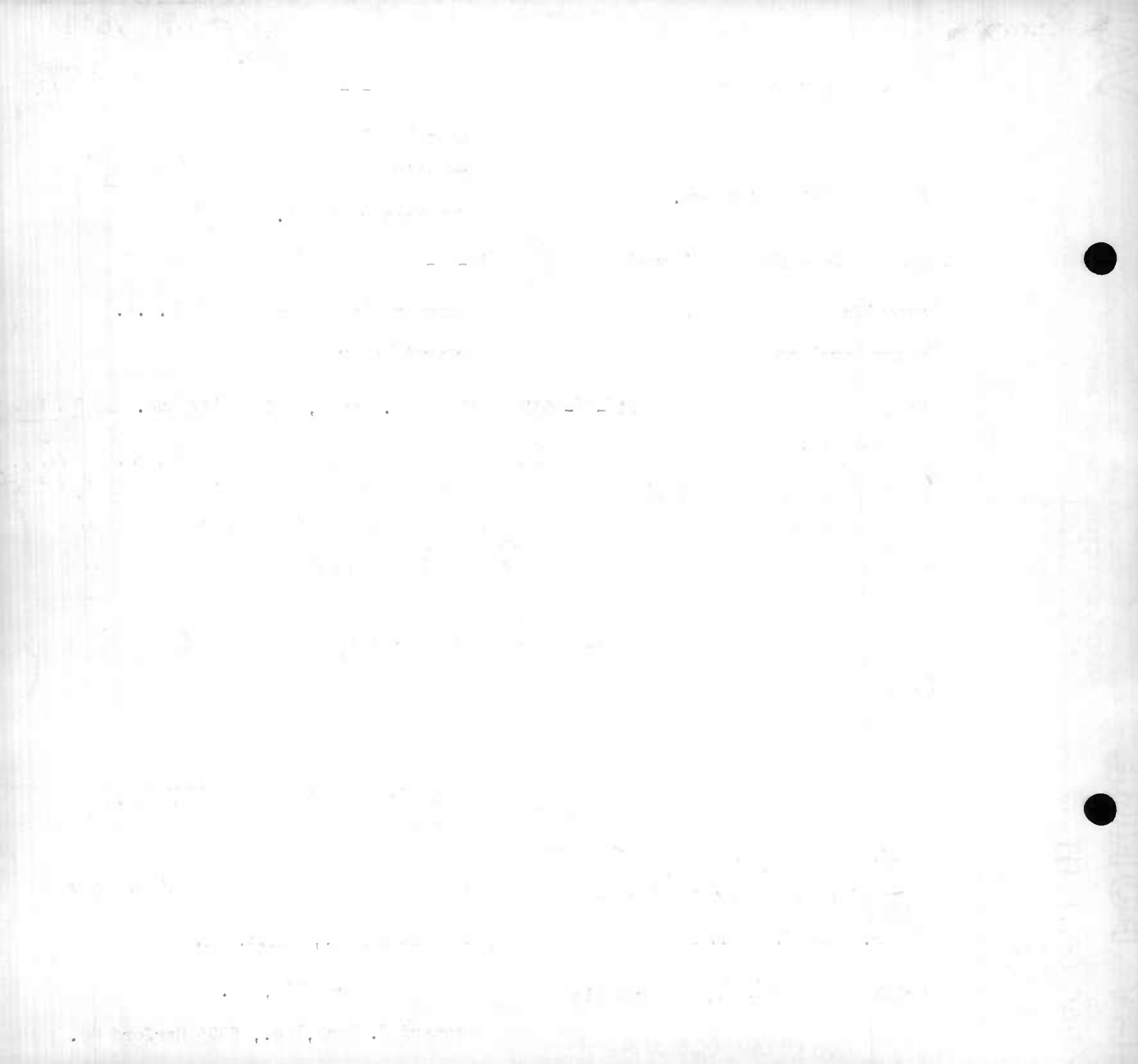
BALTIMORE CITY HEALTH DEPARTMENT																													
67 7643					CERTIFICATE OF DEATH					Registered No. 67 7643																			
BIRTH NO.																													
M.E. CASE NO.																													
1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH																			
Mary Jane Bechtel										Aug. 8, 1967 5:45 P M.																			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive										A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2709 Louise Ave.																			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 9/19/89		9. AGE (In years lost birthday) 77		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) England					12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Thomas Beer										14. MOTHER'S MAIDEN NAME Mary J. Dingle																			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. none					17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.																			
18. 2044.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) Pulmonary edema DUE TO (B) Acute lymphocytic leukemia DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH Terminal 1 wk/														
										II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
										19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
										21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?																			
22. I certify that (1) (this hospital) attended the deceased from July 28 1967 to Aug. 8 1967, that (1) (we) lost saw the deceased alive on Aug. 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.																													
23A. SIGNATURE Henry S. Crist										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 8/9/67														
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surgeon (R)										23D. ADDRESS US PHS Hospital, Balto, Md.																			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/12/67					24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore Md.														
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR AUG 10 1967					25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.					25D. ADDRESS 5305 Harford Rd. 21214														



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

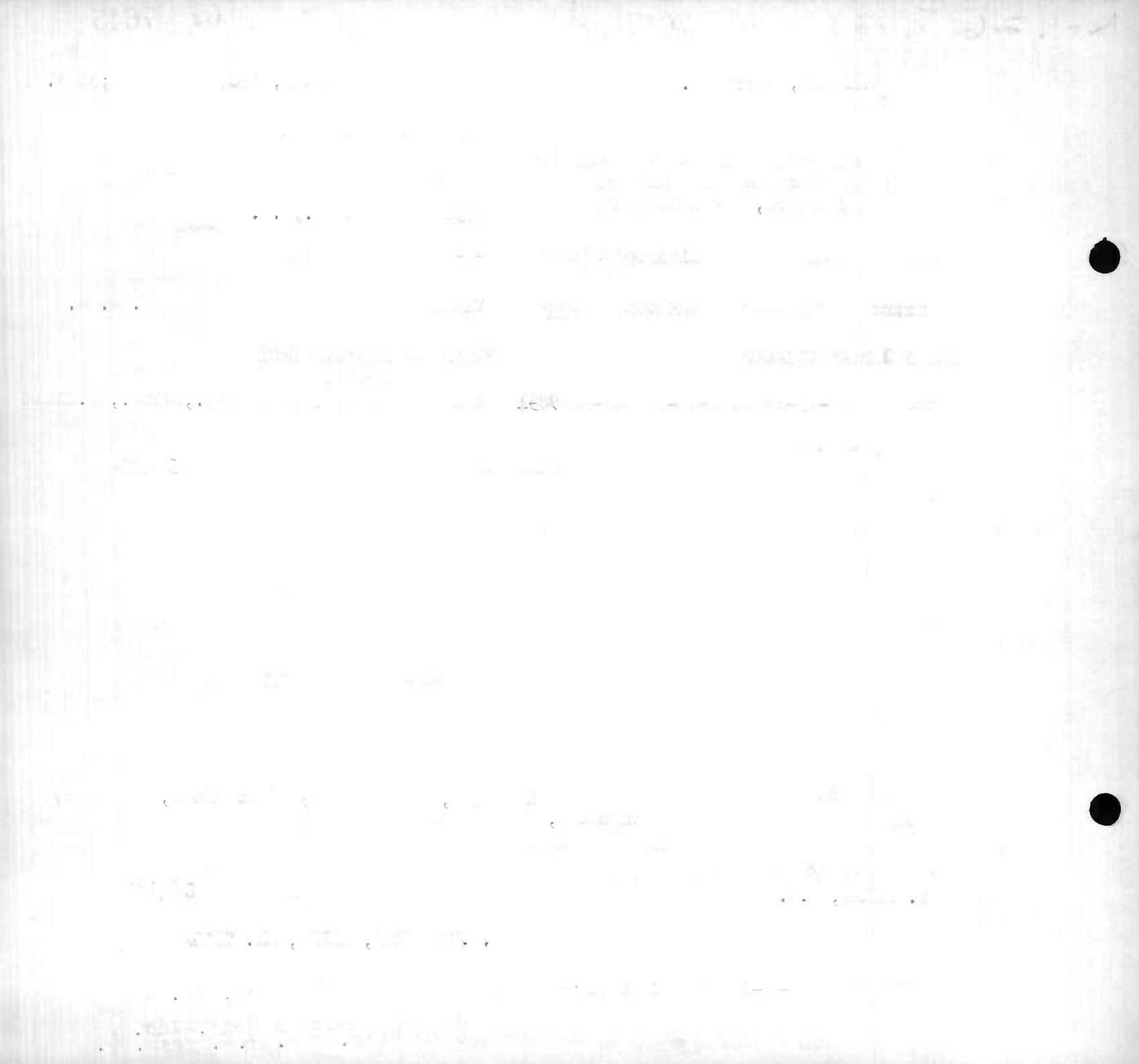
BIRTH NO. 67 7644		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7644	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Bertha Ann Rough		8-8-67 4 30 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
00 2812 White Ave.		Pennsylvania		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
00 2812 White Ave.		Franklin		D. STREET ADDRESS (If rural, give location)	
509 Kennerdell St.		5. SEX		6. RACE	
Female		Caucasian		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Widowed		8. DATE OF BIRTH		9. AGE (In years last birthday)	
10-22-80		86		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Pennsylvania		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Newton Morrison		Margaret Baker		16. SOCIAL SECURITY NO.	
No		216-56-9057		17. INFORMANT ADDRESS	
Mildred K. Rough, 2812 White Ave. BalTO. Md.		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Arteriosclerotic cardiovascular disease		Heavy years	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Coronary sclerosis		a	
ANTECEDENT CAUSES		(C) Sec. Anemia		n	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Sexuality	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 6/4 1960 to 7/5/62 1962		and that (I) (we) last saw the deceased alive on 7/5 1962 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Hans J. Koetter		23C. PHYSICIAN'S NAME (Type)		8/9/67	
23D. ADDRESS		M.D. 5600 Harford Rd., Balto. Md.		24A. BURIAL CREMATION, REMOVAL (Specify)	
Burial		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
8/12/67		Franklin		24D. LOCATION (City, town, or county) (State)	
Franklin, Pa.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		Leonard J. Ruek, Inc., 5305 Harford Rd.		25D. ADDRESS	
AUG 10 1967		Robert E. Fisher, M.D.		VS 150-REV. 1/1/64	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

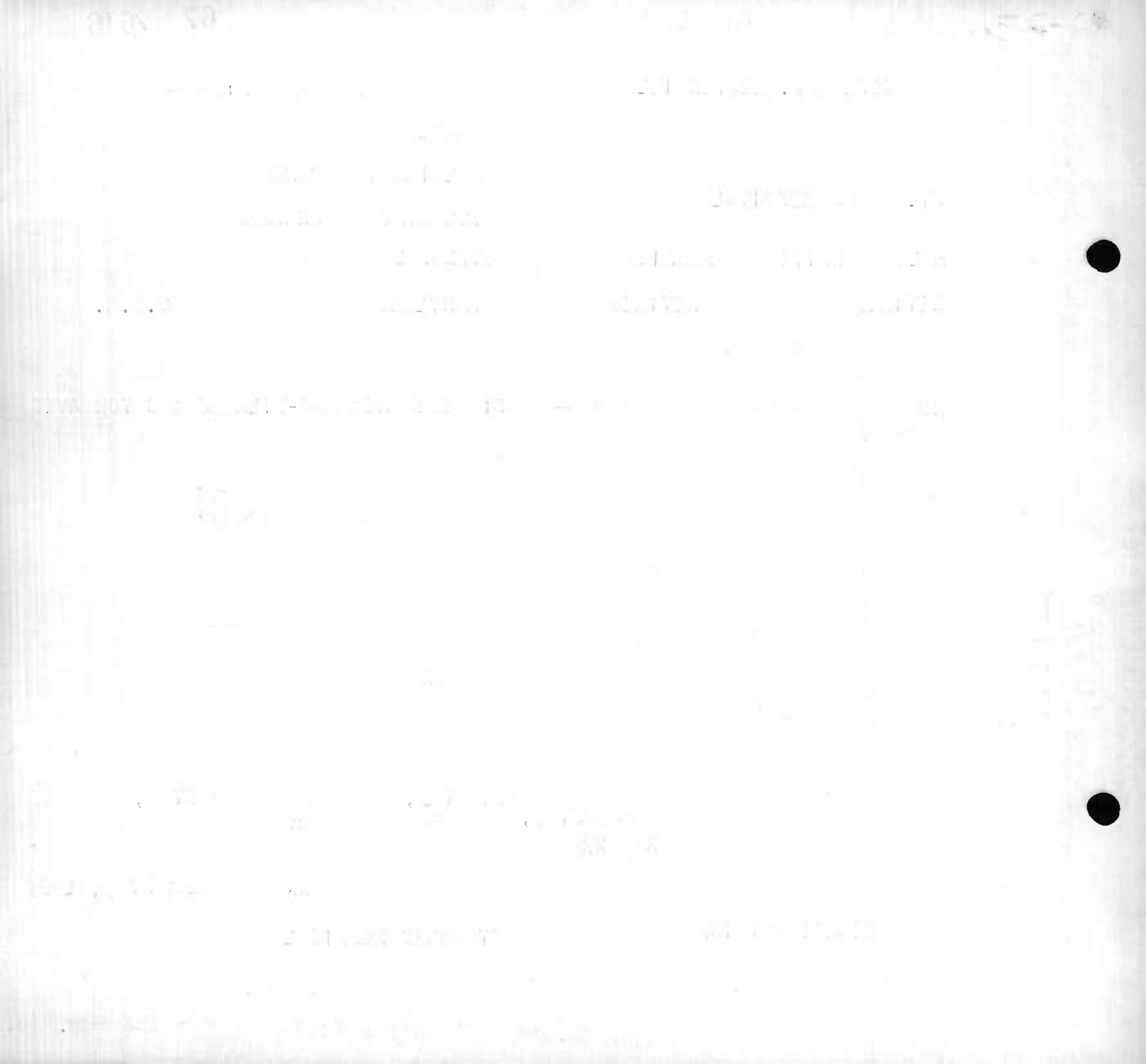
BIRTH NO. 67 7645				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7645	
1. NAME OF DECEASED (Type or Print) KILGOUR, George S.				2. DATE AND HOUR OF DEATH August 5, 1967 9:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE District of Columbia B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington			
				D. STREET ADDRESS (If rural, give location) 3731 Harrison St., N.W.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		B. DATE OF BIRTH 8-1-93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY GERDAN KILGOUR				14. MOTHER'S MAIDEN NAME FLORENCE ISABELLE LESLIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-13-18 to 1-15-19		16. SOCIAL SECURITY NO. 217-54-9831		17. INFORMANT Records ADDRESS Veterans Administration Hosp., Balto., Md. 21218			
18. 49381 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 DAYS							
19. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from August 1, 1967 to August 5, 1967 , that (2) (we) last saw the deceased alive on August 5, 1967 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. MULAY, M.D.				23B. DATE SIGNED 8/7/67		23C. PHYSICIAN'S NAME (Type) V.A. HOSPITAL, BALTO, MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8-9-1967		24C. NAME OF CEMETERY or CREMATORY Hillsboro Cemetery		24D. LOCATION (City, town, or county) (State) Hillsboro, Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		ADDRESS 5130 Wise Ave. N.W. Wash. DC.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

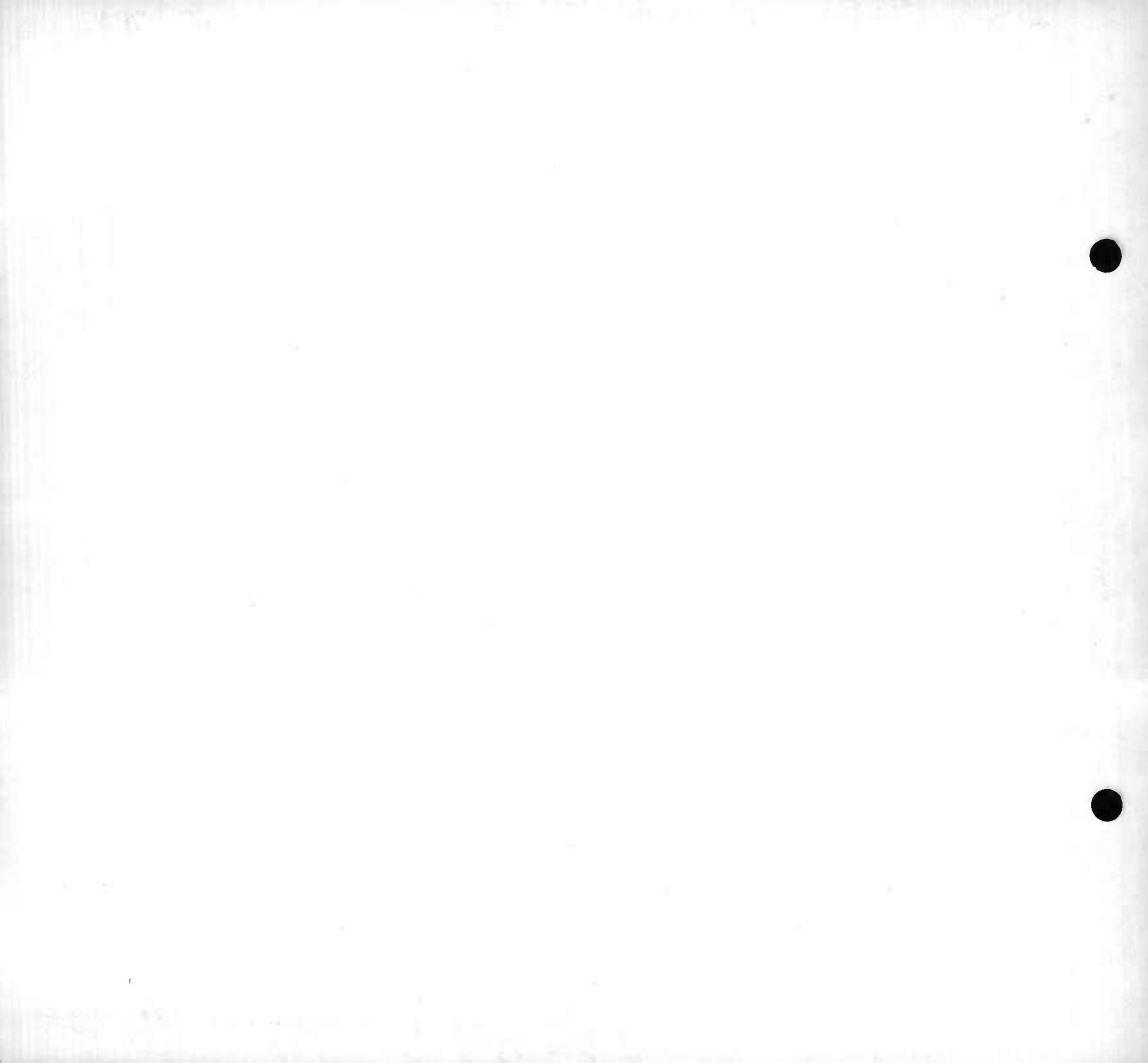
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7646	
BIRTH NO. 67 7646		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPH P. WESTERFIELD		2. DATE AND HOUR OF DEATH 08/07/67 3:50 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228			
		D. STREET ADDRESS (If rural, give location) 122 NORTH BEECHWOOD AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/26/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Augustus Westerfield		14. MOTHER'S MAIDEN NAME Anna Kress			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO none		16. SOCIAL SECURITY NO. 215-03-8790		17. INFORMANT ADDRESS ST AGNES RECORDS-WILKENS & CATON AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Ischemia		CAUSE OF DEATH (A) DUE TO Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 3, 1967 to AUGUST 7, 1967 , that (I) (we) lost saw the deceased alive on AUGUST 7, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE  GEORGE PATRICK				23B. DATE SIGNED AUGUST 7, 1967	
23C. PHYSICIAN'S NAME (Type) GEORGE PATRICK		23D. ADDRESS ST AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 8, 1967		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS STERLING FUNERAL ESTATE 736 Edm. Av. Catonsville	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7647		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7647	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) FRISCH		MRS. ANN M.		8/6/67 11:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
CHURCH HOME & HOSPITAL			Md. 26-44		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			BALTO		
D. STREET ADDRESS (If rural, give location)			128 N JANNEY ST.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W		10/3/88	78	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Shipley			Mary Cole		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Joseph Frisch, Jr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		ADDRESS	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Anterograde cardiac		Same address	
ANTECEDENT CAUSES		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Congestive Failure			
		(B) DUE TO			
		Pneumonia, R base			
		Pyelonephritis due to E. coli			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hypoproteinemia & Anasarca			
		Anemia, etiol. unknt.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28/67 to 8/6/67 that (I) (we) last saw the deceased alive on 8/6/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Francisco Baltazar, Jr.				8/6/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANCISCO BALTAZAR, JR.		CHURCH HOME & HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Aug 9, 1967		Meadowridge	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Md.		AUG 10 1967			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Robert E. Farley, Jr.		Thelma Hoffmann		3218 Hudson St.	

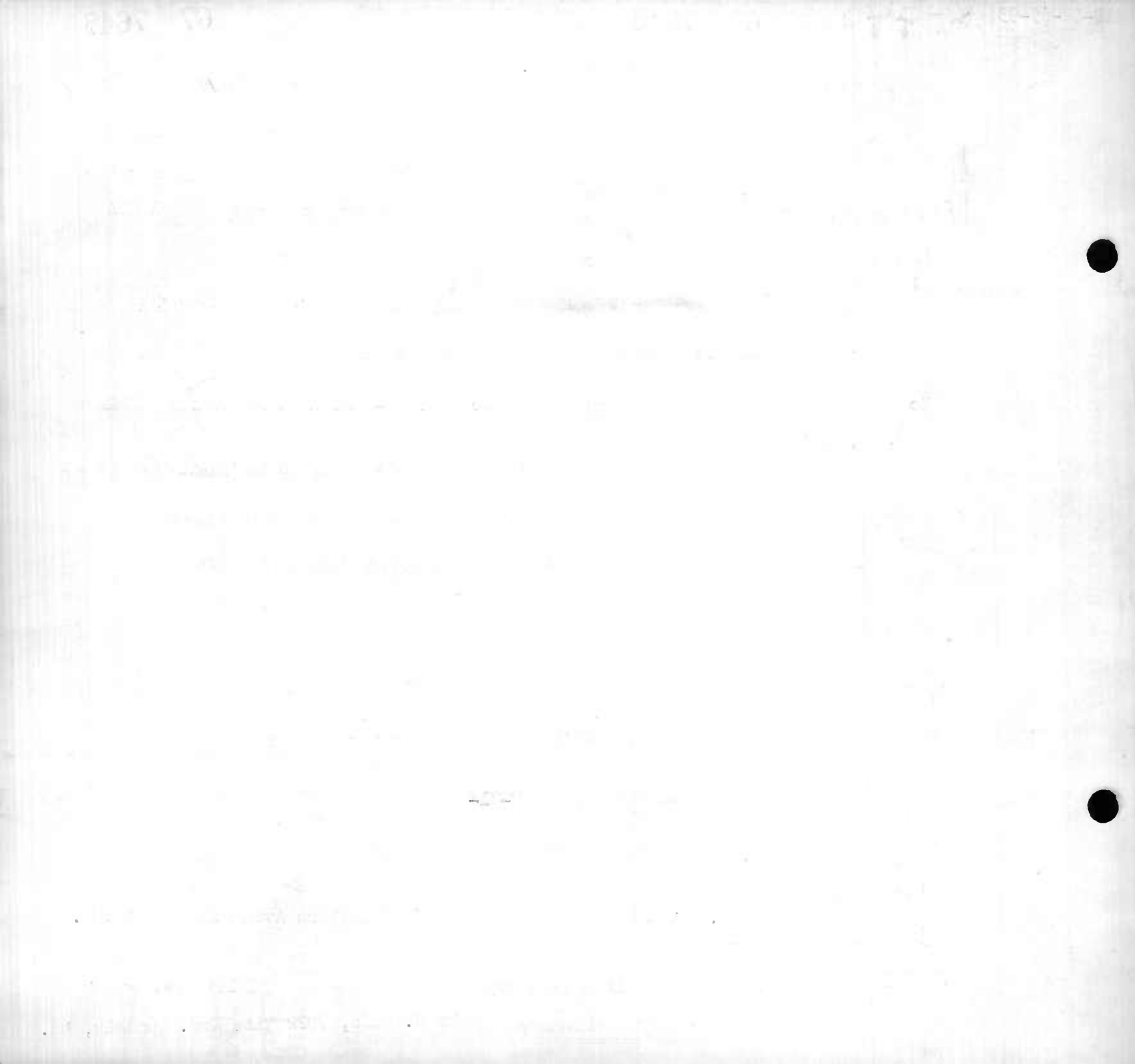


CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KATHERINE RIEGEL		2. DATE AND HOUR OF DEATH 8/8/67 - 6:00 AM		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore Co					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland 21224 BALTIMORE CITY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				53-00	
D. STREET ADDRESS (If rural, give location) 7501 RIDDLE AVE				21224					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/22/00	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Becker			14. MOTHER'S MAIDEN NAME Anne Foeble						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X1			CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO			INTERVAL BETWEEN ONSET AND DEATH 18 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES			(B) DIABETES MELLITUS-ADULT ONSET DUE TO						
(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES									
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from: 7-21-1967 to Aug 8 1967 , that (I) (we) lost saw the deceased alive on aug 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE David E. McBeth						23B. DATE SIGNED 8/8/67			
23C. PHYSICIAN'S NAME (Type) DAVID E. MCBETH		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 6060 E. PRATT ST.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/67		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Farley, MA		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7649	
BIRTH NO. 67 7649		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. GLADYS MASON HAYWARD		2. DATE AND HOUR OF DEATH AUG. 9, 1967 7:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION HOME: Broadview Apartments - - -		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City of Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) Univ. Pkwy. and 39th Streets			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Nov-5-1983	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James E. Mason		14. MOTHER'S MAIDEN NAME Edith Cherry	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-6849		17. INFORMANT Miss Cherry, Baltimore 21210	
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) in aneurism - generalized atherosclerosis many years		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. multiple CVD, mesenteric artery insufficiency		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to present that (I) (we) last saw the deceased alive on approx. one year ago and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 8-9-67	
23C. PHYSICIAN'S NAME (Type) F. W. DAVIS				23D. ADDRESS M.D. 11 E. Chase St Balto 2	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 8/11/67		24C. NAME OF CEMETERY or CREMATORY GREEN MOUNT CEMETERY	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Stewart & Mowen Co. 108 W. North Av., City			



W-325

67 7650

BALTIMORE CITY HEALTH DEPARTMENT

67 7650

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **Epwin R. WATKINS** 2. DATE AND HOUR PRONOUNCED DEAD **August 5, 1967 10:46 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland A. STATE B. COUNTY **27-03**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **2907 Rueckert Ave, Balto**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Oct 16, 1923** 9. AGE (In years last birthday) **43**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Officer Worker** 10B. KIND OF BUSINESS OR INDUSTRY **Credit Agency**

11. BIRTHPLACE (State or foreign country) **Youngstown Ohio** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Edwin** 14. MOTHER'S MAIDEN NAME **Laura Bergman**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **296-18-8401**

17. INFORMANT **Mrs Margaret M. Watkins** ADDRESS **526 E 20th Street, Apt 1C Baltimore, Maryland**

18. **E983X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Asphyxia (A) DUE TO **Smothering**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **NO** 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Street**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Rear of 1302 Pennsylvania Ave. (Shafers Tavern)**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **UNK UNK m.** 21E. INJURY OCCURRED **WHILE AT WORK**

21F. HOW DID INJURY OCCUR? **Subj. choked by unidentified person**

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **8/5/67**

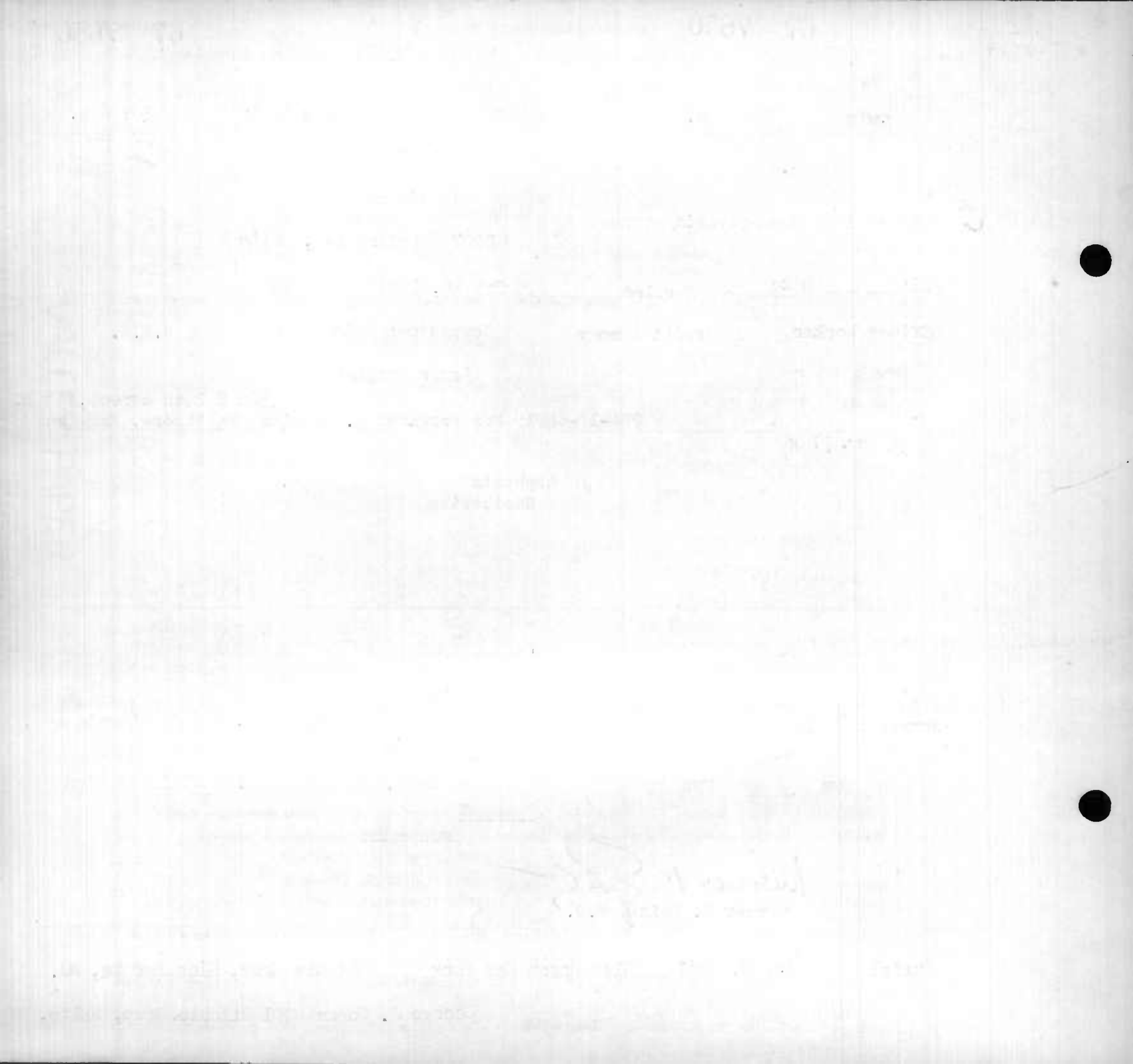
EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **Aug 8, 1967** 23C. NAME of CEMETERY or CREMATORY **Glen Haven Mem Park**

23D. LOCATION (City, town, or county) (State) **Ritchie Hwy, Glen Burnie, Md.**

24A. DATE REC'D BY HEALTH DEPT. **AUG 10 1967** 24B. NAME OF REGISTRAR **Robert E. Fairbank** 24C. FUNERAL DIRECTOR **George J. Gonce** ADDRESS **4001 Ritchie Hwy, Balto, Md**

VS 151-REV. 1/1/65



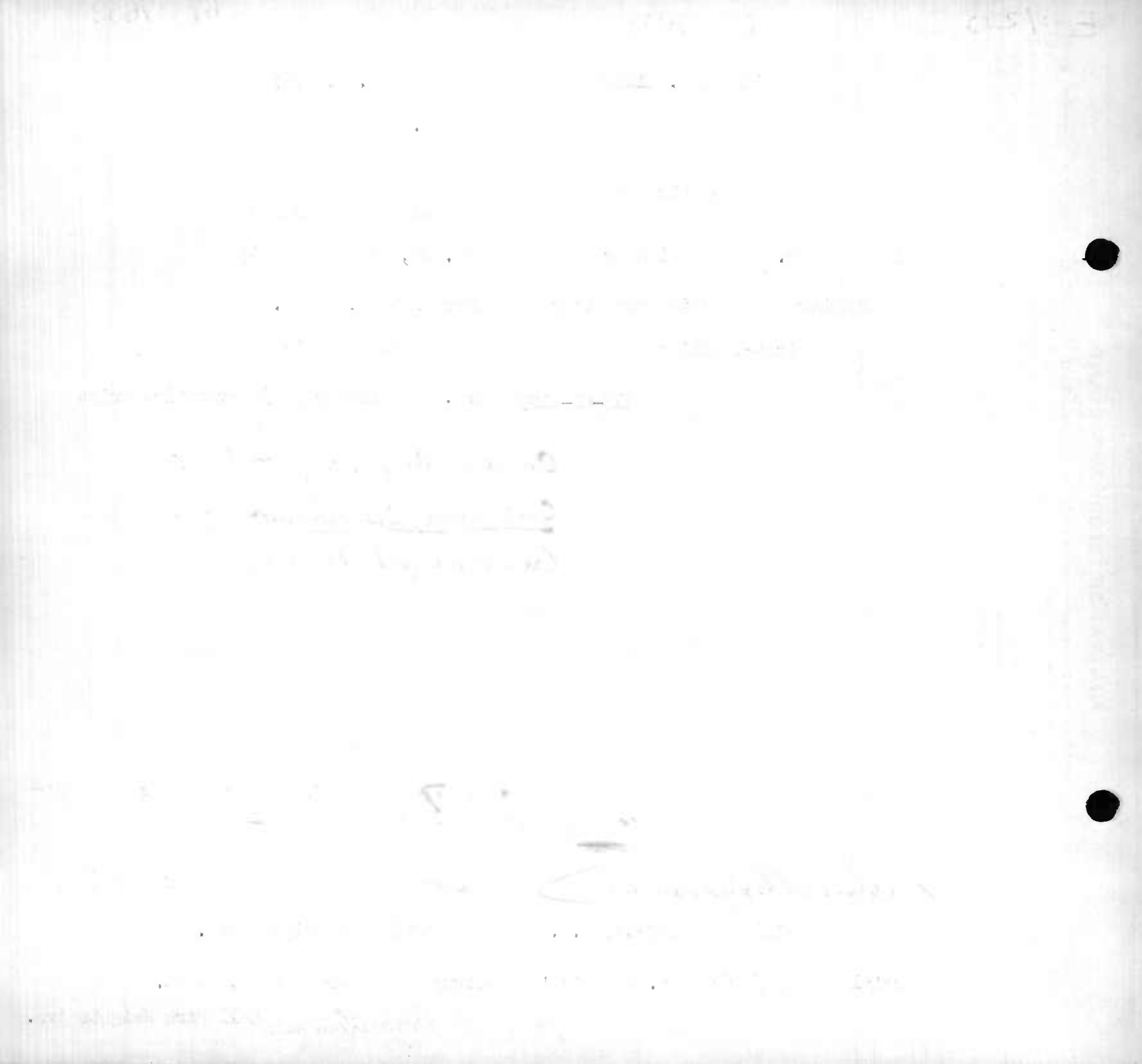
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Carroll Co., Md. 67</i> 7651		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7651	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) KEITH ALLAN SINNOTT				2. DATE AND HOUR OF DEATH 8-7-67 1:30 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY <i>Carroll Co</i>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) UNION BRIDGE		D. STREET ADDRESS (If rural, give location) ROUTE 1	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7-23-67	9. AGE (In years last birthday) 15	If Under 1 Yr. Months: Days: Hours: Min. 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME JAMES L. SINNOTT JR.		14. MOTHER'S MAIDEN NAME NAOMI Burrier	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James L. Sinnott, Jr. Union Bridge, Md.	
18. <i>756.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ASPIRATION AND RESPIRATORY OBSTRUCTION		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 12 HR	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) VOMITING		12 HR	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PREMATURITY		(C) INTEST. OBSTRUCTION - PROB CONGENITAL AGANGLIONIC MEGACOLON			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-7-67 19 to 8-7-67 19, that (I) (we) last saw the deceased alive on 8-7-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James R Brown</i>				23B. DATE SIGNED 8-8-67	
23C. PHYSICIAN'S NAME (Type) JAMES R BROWN				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/67		24C. NAME OF CEMETERY or CREMATORY Mountain View Cemetery	
24D. LOCATION Union Bridge, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Robert E. Finkbeiner	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR D. D. Hartzler & Sons, Union Bridge Maryland	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7652		BALTIMORE CITY HEALTH DEPARTMENT		67 7652		
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH		Registered No.		
(Type or Print)		Michael B. Elias		Aug. 6, 1967		M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY		
00		3413 Devonshire Drive		Md.		27-20		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)				
Baltimore				3413 Devonshire Drive				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Male	Cau.	Widower	Jan. 27, 1904	63	Butcher	Carrollstown, Penna.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Butcher			Chain Food Store		Carrollstown, Penna.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Michael Elias				Susanne Belensky				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		213-01-2183		Mrs. Anne Lohrey, 3413 Devonshire Drive				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Cardio-Respiratory Failure						
ANTECEDENT CAUSES		(B) Car-carcinoma of Lung						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Generalized Metastasis						
II								
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Oct 7 1966 to Aug 6 1967, that (I) (we) last saw the deceased alive on Aug 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.								
23A. SIGNATURE				23B. DATE SIGNED				
Willard Applefeld, M.D.				8/8/67				
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS				
Willard Applefeld, M.D.				5901 Park Heights Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial		8/9/1967		St. Benedict's Cemetery		Carrollstown, Penna.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		
AUG 10 1967		Robert E. Farley		C. Vernon Lemmon		4611 Park Heights Ave.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7653				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7653	
1. NAME OF DECEASED HARTMAN HILMA CLEMENTINE				2. DATE AND HOUR OF DEATH AUGUST 9, 1967 4:30 A.M. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL WILKENS AND CATON AVE BALTIMORE MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-33			
5. SEX FEMALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED MARRIED	
8. DATE OF BIRTH 08 05 87				9. AGE (In years lost birthday) 79 80		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Clement LEHNERT			
14. MOTHER'S MAIDEN NAME MARIE LINNAMAN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 216-05-5202				17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) diabetic acidosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. diabetic mellitus II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 8/1/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene foot		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 7, 1967 to AUGUST 9, 1967 , that (I) (we) lost saw the deceased alive on AUGUST 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jaime V. Del Pilar				23B. DATE SIGNED 8/9/67		23C. PHYSICIAN'S NAME (Type) JAIME DEL PILAR	
23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12 Aug. 67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Robert P. Moore		25D. ADDRESS Singleton Funeral Home/Glen Burnie, Md.	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/10/2001 BY 60322
UCBAW

WHITE MALE

BALTIMORE WASHINGTON

CLARENCE LEMBERT

WHITE LINGUIN

ST AGNES HOSPITAL CATON & WILLIAM AVE

AUGUST 9

JULY 28

CLARENCE LEMBERT

ST AGNES HOSPITAL CATON & WILLIAM AVE

1
F-450

67 7654 BALTIMORE CITY HEALTH DEPARTMENT

67 7654

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARY

FLYNN

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967

2:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

203 W. Read St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

203 W. Read St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

?

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BAR MAID

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO - MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

196-146598

17. INFORMANT

ADDRESS

E. RICHARD SINNIS 21212 703 E. GITTINGS AVE

18. E970.8

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Overdose of Placidyl

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

203 W. Read St. 11-03

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

UNK

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

ingested an overdose of drugs

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

Aug 9-67

23C. NAME of CEMETERY or CREMATORY

ST MATTHEW'S CEM

23D. LOCATION

(City, town, or county)

(State)

O'Donnell ST Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Duggan Brothers Inc 1800 E Lombard

ADDRESS

Completed

WALLACE & GORDON

1897

1897

WALLACE & GORDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7655		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7655	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) RUTH L. SMITH			2. DATE AND HOUR OF DEATH AUG. 7, 1967 7:15PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-05		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 540 DUNDALK AVE. #21224		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 11, 1924	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) KENTUCKY, LOUISVILLE		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JAMES BURNS			14. MOTHER'S MAIDEN NAME LILBURN EAST		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT RAYMOND W. SMITH		ADDRESS SAME.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 581.0 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA			CAUSE OF DEATH (A) DUE TO POST-STROKE ENCEPHALOPATHY (B) DUE TO RENAL FAILURE; GI BLEEDING (C) MALNUTRITION		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-13-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PORTAL GASTROSIS		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18-67 to 8-7-67 that (I) (we) last saw the deceased alive on 8-7-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Asst. Dir.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-7-67
23C. PHYSICIAN'S NAME (Type) DR. A. de Leon			23D. ADDRESS CH & H		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-10-67	24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS CEM		24D. LOCATION (City, town, or county) (State) 6515 BOSTON AVE., BALTO., MD.
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR R. E. F.		25C. FUNERAL DIRECTOR 6224 EASTERN AVE., BALTO., MD.	

SOUTH HAVEN, CONNECTICUT
100 NORTH WINDY
BARTHOLOME, MARYLAND

PART 1182

240 DUNDAS AVE.

MAY 11, 1954 AS

MARRIED

TEMPERATURE

HOUSEWIFE

ELIZABETH EAST

Post-acute respiratory
renal failure; 8-1

Malnutrition

7-12-57 Post-acute respiratory

NO

8-2-57 8-12-57 8-1-57

Dr. A. A. A.

Dr. A. A. A.

CH & H

L-523

67 7656

BALTIMORE CITY HEALTH DEPARTMENT

67 7656

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ROSILINE

(Rose)

LANSDOWNE

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1967

6:23 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2001 North Dennison Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2001 North Dennison St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

Jan 9, 1890

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Jamico, British West Indies U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

THOMAS REID

14. MOTHER'S MAIDEN NAME

MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Inez Blackstone 3427 Mondawmin

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic and Hypertensive
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-12-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park Arbutus, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1967

24B. NAME OF REGISTRAR

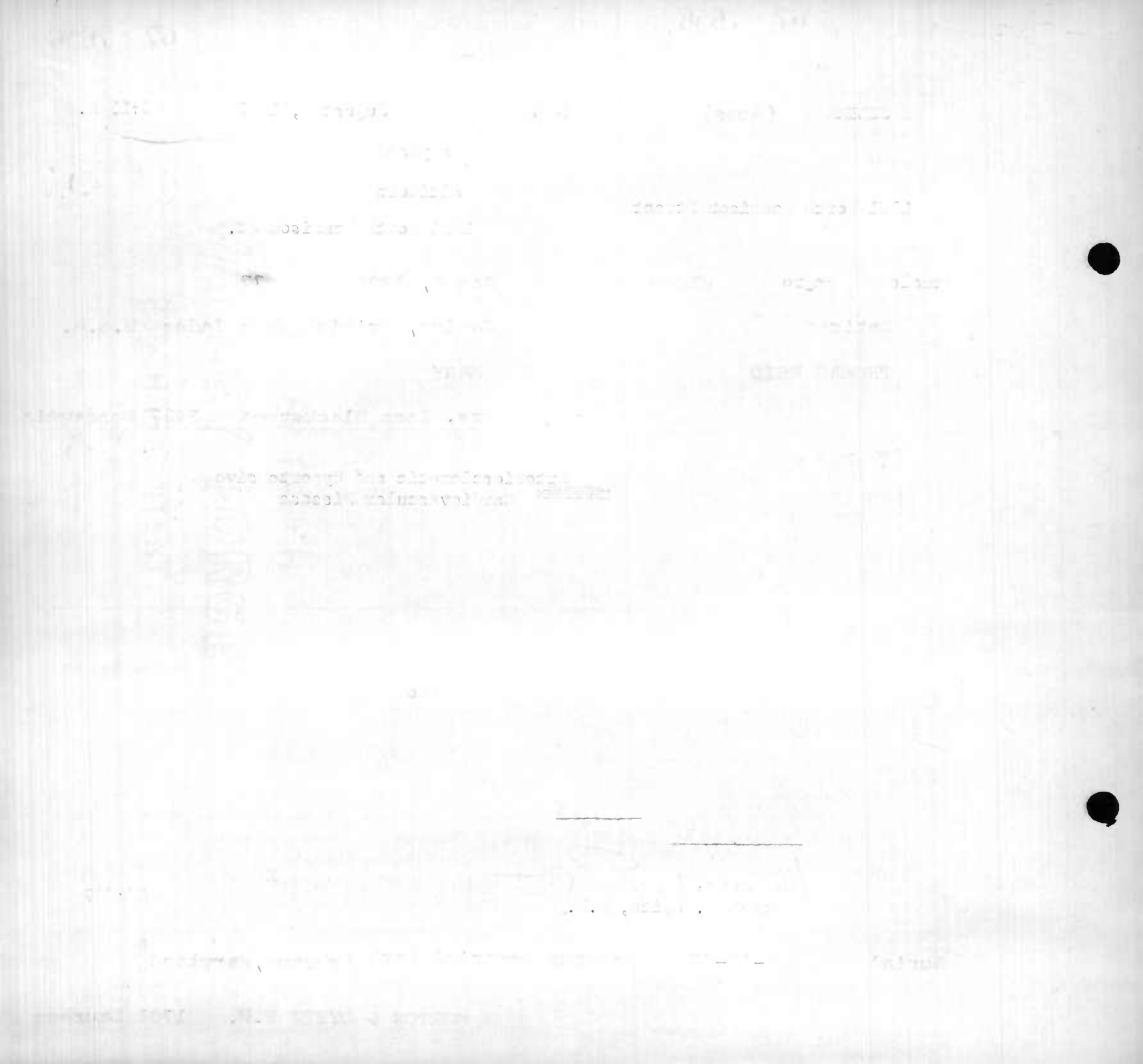
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

ADDRESS

1701 Laurens



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7657		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7657	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print) HERRING, McKINLEY NMI			2. DATE AND HOUR OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
27 VETERANS ADMINISTRATION HOSPITAL			M. RYLAND BALTIMORE CITY		
3900 LOCH RAVEN BOULEVARD			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
BALTIMORE, MARYLAND 21218			BALTIMORE		
D. STREET ADDRESS (If rural, give location)			15-47		
3304 CLIFTON AVENUE					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
MALE	NEGROID	MARRIED	2/25/07	60	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
DOMESTIC WORKER			NORTH CAROLINA		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
TOMAN HERRING			MITTIE ROBINSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
YES 3/30/18 TO 7/23/19			219-01-6653		VA HOSPITAL RECORDS
			3900 LOCH RAVEN BLVD, BALTO, MD 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) Pulmonary Edema		
ANTECEDENT CAUSES			DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Possible myocardial infarction		
			DUE TO		
			(C) status post-operative lipo-sarcoma		
			left retro-peritoneal area		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 12 JULY 19 67 to 7 AUGUST 19 67, that (X) (we) last saw the deceased alive on 7 AUGUST 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
VICTOR V. J. BORGES				8/8/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
VICTOR V. J. BORGES				3900 LOCH RAVEN BOULEVARD	
				BALTIMORE, MARYLAND 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-11-67		Balto, Nat'l Cem.	
				Baltimore	
				Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 10 1967		MORTON & DYETT F.H.		1201 Laurens	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7658</u>	
BIRTH NO. <u>67 7658</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ANNA R. RINGLING</u>		2. DATE AND HOUR OF DEATH <u>8-8-67</u> <u>7:45 AM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1811 AISQUITH STREET</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-12-09</u>	9. AGE (In years lost birthday) <u>57</u>	If Under 1 Yr. (Months) Days Hours Min. (If Under 24 Hrs. Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>A.A. Co., Maryland</u>	
13. FATHER'S NAME <u>JOHN STEVENSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA WRIGHT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-09-9863</u>		17. INFORMANT ADDRESS <u>Mr. Thomas Ringling 1811 Aisquith St.</u>	
18. <u>443 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (B) <u>HYPERTENSIVE CARDIOVASC. DIS.</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>30 HOURS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> 19 <u>67</u> to <u>8-9</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-7</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Major W. Braoshaw</u> M.D.				23B. DATE SIGNED <u>8-8-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>MAJOR W. BRAOSHAW</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSP</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-10-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. STATE <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTON & DYETT F.H. 1701 Laurens St.</u>	

NOV 10 1967

HYPERSENSITIVE REACTION
TO ANAESTHETIC DRUGS

Yes

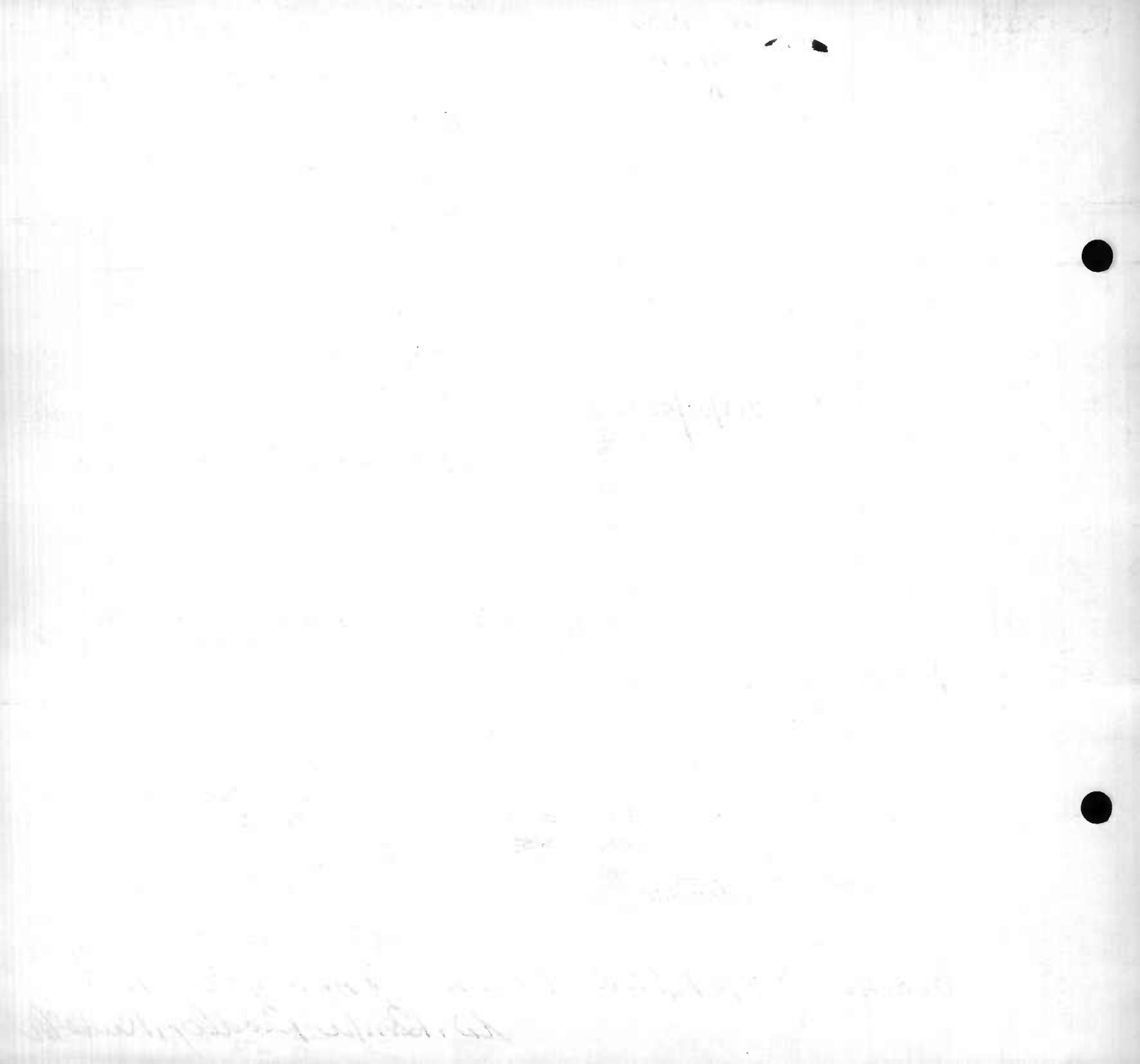
MAJOR W. BRADSHAW
JAMES H. BRADSHAW

-10-67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7659		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7659	
M.E. CASE NO.		FALLIN			
1. NAME OF DECEASED (Type or Print) MRS NAOMIA ROWE		2. DATE AND HOUR OF DEATH 8-4-47 10:45 PM.		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY Hospital		A. STATE BALTIMORE B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK		53-00	
		D. STREET ADDRESS (If rural, give location) 48 S. DUNDALK AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-18-82	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Fallin		14. MOTHER'S MAIDEN NAME Mary Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213/07/20000		17. INFORMANT ADDRESS CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH PROBABLE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Fx Hip 2wks ago 10 days post-op total colectomy for SEVERE DIVERTICULITIS			
19A. DATE OF OPERATION 2 wks ago	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hip	20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) YES	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hip Fx at Home	21C. WHERE DID INJURY OCCUR? 48 S. DUNDALK AVE		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 2 wks ago (July 17)	21E. INJURY OCCURRED While At Work Not While At Work	21F. HOW DID INJURY OCCUR? SLIPPED + FELL AT HOME			
22. I certify that (this hospital) attended the deceased from July 17 19 47 to August 4 19 47 that (we) lost saw the deceased alive on Aug 4 19 47 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE James J. Stedman		23B. DATE SIGNED 8-4-47	
23C. PHYSICIAN'S NAME (Type) M.D. Mercy Hospital - Baltimore		23D. ADDRESS M.D. Mercy Hospital - Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/5/67	24C. NAME OF CEMETERY or CREMATORY OAK LAWN	24D. LOCATION BALTO, Co., Md	(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT AUG 10 1967	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR W. Lawrence Bradley, Dundalk	ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7660	
BIRTH NO. 67 7660		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BESSIE EVANS		2. DATE AND HOUR OF DEATH 4:05 PM 8/7/67 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY F			
FULL NAME OF HOSPITAL OR INSTITUTION 42		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4100 Westchester RD 21216			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 8/17/17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Mike Williams		14. MOTHER'S MAIDEN NAME Snah Spanner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Otis Evans Evans	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sarcoma of uterus & widespread metastasis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/7/67 to 8/7/67 that (I) (we) last saw the deceased alive on (died half an hour after arrival to hospital) and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AU Hagg		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/67	
23C. PHYSICIAN'S NAME (Type) AZHAR-UL-HAG		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-11-67	24C. NAME of CEMETERY or CREMATORY Balto Nat Cem		24D. LOCATION (City, town, or county) (State) Balto MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Elroy C. Wilson	
				ADDRESS 1000 Briantown	

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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 7661				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7661	
1. NAME OF DECEASED (Type or Print) MOORE, RAYMOND EDWARD				2. DATE AND HOUR OF DEATH 8-8-67 3:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY Kent Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHESTERTOWN D. STREET ADDRESS (If rural, give location) ROUTE 1			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 8-6-07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY LUMBAR YARD		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM MOORE				14. MOTHER'S MAIDEN NAME SARAH SAVINGTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-12-0046		17. INFORMANT ST AGNES HOSPITAL RECORDS, 1000 S CATON AVE., BALTO., MD. 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				CAUSE OF DEATH (A) Intrathoracic malignancy DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-29-67 to 8-8-67 , that (I) (we) last saw the deceased alive on 8-8-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ramon Suarez				23B. DATE SIGNED 8-8-67			
23C. PHYSICIAN'S NAME (Type) RAMON SUAREZ		23D. ADDRESS ST AGNES HOSPITAL, BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE AUG. 12	24C. NAME OF CEMETERY or CREMATORY CRUMPTON		24D. LOCATION (City, town, or county) (State) CRUMPTON MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Edgar L. Lane Church Hill Md			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 520		67 7662		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7662	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) CORA LEE JONES			
2. DATE AND HOUR OF DEATH 8/8/67 12:50 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1134 Stoddard Court 21201			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated		8. DATE OF BIRTH 1-26-1920	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lilly				14. MOTHER'S MAIDEN NAME Dora Moore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Widespread metastatic cancer ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Multiple Decubiti				CAUSE OF DEATH (A) Widespread metastatic cancer DUE TO (B) cancer DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/7 1967 to 8/8 1967 , that (I) (we) last saw the deceased alive on 8/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Zachary Grossman M.D.				23B. DATE SIGNED 8/8/67		23C. PHYSICIAN'S NAME (Type) Zachary Grossman M.D.	
23D. ADDRESS 586 E. Pratt St. Baltimore 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

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Report of the Hudson River
Fishing and Game Commission

J-250

67 7663

BALTIMORE CITY HEALTH DEPARTMENT

67 7663

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICK

L.

JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

August 7, 1967

3:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

238 Wilson Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
238 Wilson Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

3-15-00

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Regina Jackson

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-12-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 10 1967

R. E. Farley, M.D.

Kelson Funeral Home 1348 Calhoun St

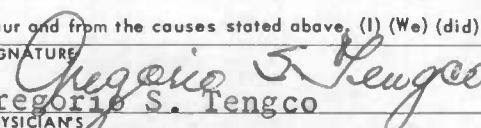
married 8-12-00 67

Regina Jackson

Burial 8-12-00 Regina Jackson
Funeral Home 1246

FUNERAL DIRECTOR: IMPORTANT

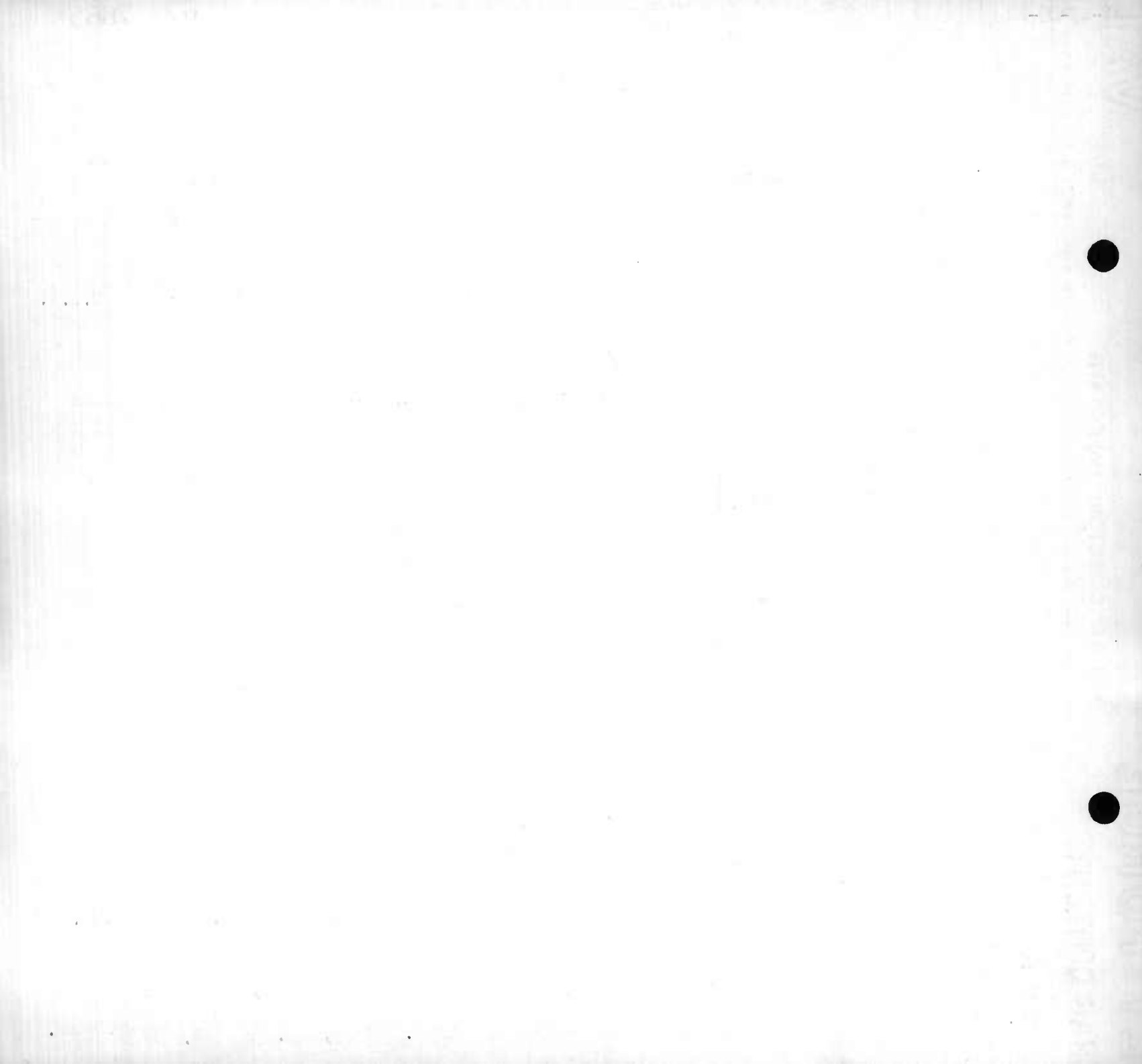
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7664	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Pinkett Maggie </div> <div> 2. DATE AND HOUR OF DEATH 8-5-67 (EOR) 10:20 P.M. </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217 </div> <div style="flex: 1; font-size: small;"> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 2005 Brunt Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-24-08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 215-01-4819A		17. INFORMANT Elijah Cousin, Son		ADDRESS SAME	
18. 522X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Pulmonary edema Heart Failure (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 5, 1967 to August 5, 1967, that (I) (we) last saw the deceased alive on August 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  Gregorio S. Tengco				23B. DATE SIGNED 8-9-67	
23C. PHYSICIAN'S NAME (Type) Gregorio S. Tengco		23D. ADDRESS 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-5-67	24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

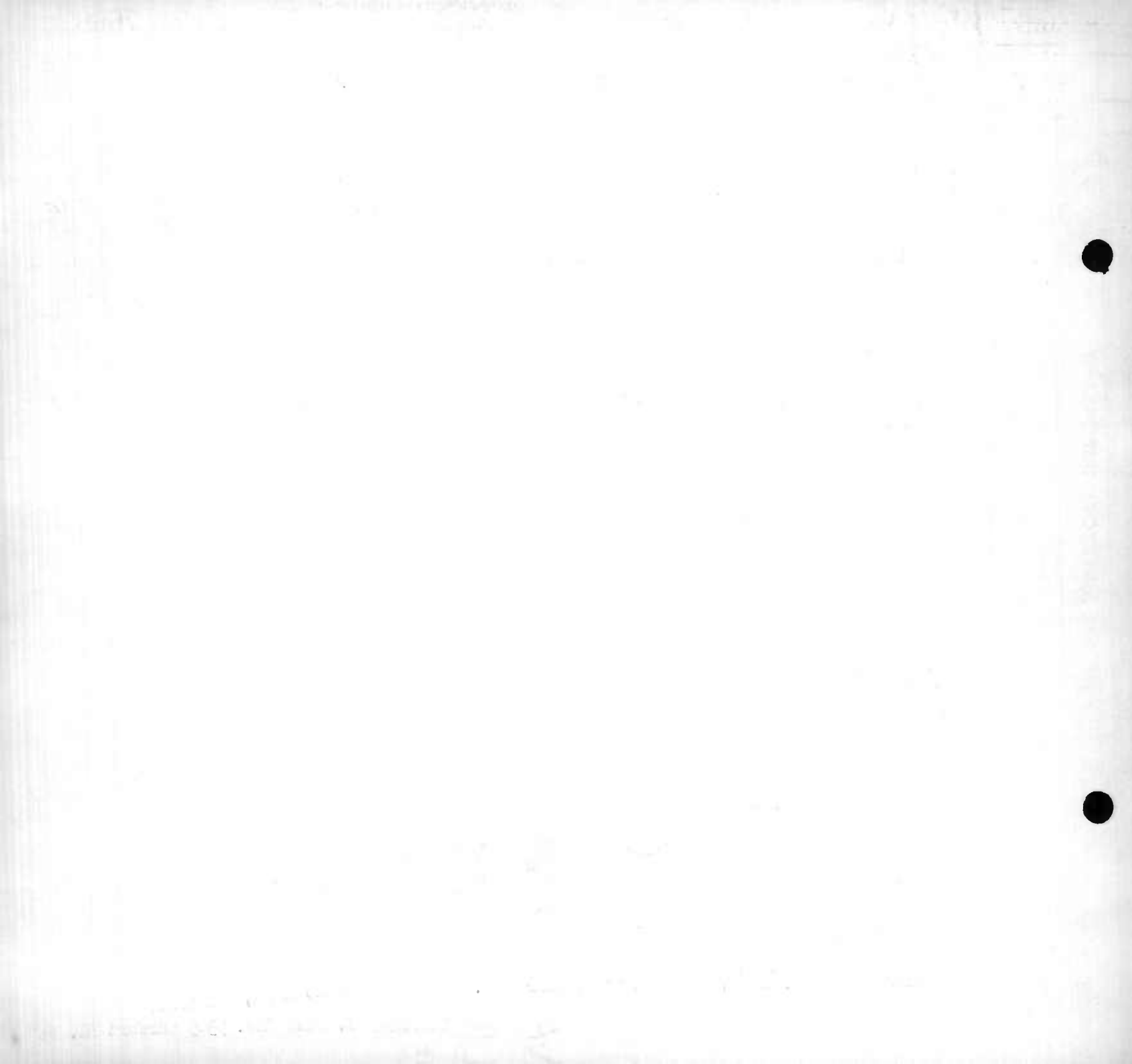
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-432		67 7665		BIRTH NO.		67 7665		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROSALIE S. SOLTYSIAK				2. DATE AND HOUR OF DEATH AUGUST 8, 1967 11:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTIMORE CITY HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 11 S. CASTLE ST 21231					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-7-08		9. AGE (In years last birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Ozimek				14. MOTHER'S MAIDEN NAME Julia					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-00-7273MA		17. INFORMANT Records: ECM-4940 Eastern Avenue 21224			
18. 433.0 + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cardiac arrest				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO pulmonary embolus atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus Congestive Heart failure, gangrene (leg)				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from July 12 19 67 to August 8 19 67 , that (X) (we) last saw the deceased alive on August 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joel Thurn				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/8/67	
23C. PHYSICIAN'S NAME (Type) JOEL THURN				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR John A. Moran, Inc.		ADDRESS 3000 E. Baltimore St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7666	
BIRTH NO. M.E. CASE NO.		67 7666		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		GIORGILLI AMEDEO		2. DATE AND HOUR OF DEATH 8/9/67 8:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
37 MERCY HOSP.		5725 UTRECHT RD #6		D. STREET ADDRESS (If rural, give location)	
5. SEX MALE	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/6/1910	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CONSTRUCTION		WORKER		BALTO, MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FRANCIS GIORGILLI		BINCENZIA LUCCIARILLI		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN (no)		213-07-3291		MRS Angela Giorgilli - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO PERITONITIS		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Carcinoma - stomach		Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7/14 + 8/7/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPL. COLONIC POLYP + LAP.		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12 19 67 to 8/9 19 67, that (I) (we) last saw the deceased alive on 8/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Susan Bollinger		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) M. SUSAN BOLLINGER		23D. ADDRESS MERCY HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967	
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14			



B-220

67 7667 BALTIMORE CITY HEALTH DEPARTMENT

67 7667

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST S. BUKOWIEC

2. DATE AND HOUR PRONOUNCED DEAD

August 9, 1967 12:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1259 E. Belvedere Ave. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1259 E. Belvedere Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10/21/1923

9. AGE (In years
last birthday)

44

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Rate Clerk

10B. KIND OF BUSINESS OR INDUSTRY

B&P Motor Express

11. BIRTHPLACE (State or foreign country)

Nantikoke, Penna.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ignatius Bukowiec

14. MOTHER'S MAIDEN NAME

Lillian Bukowiec (nee Ciampola)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

192144649

17. INFORMANT

Mrs. Lillian Bukowiec— Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

August 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/12/67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

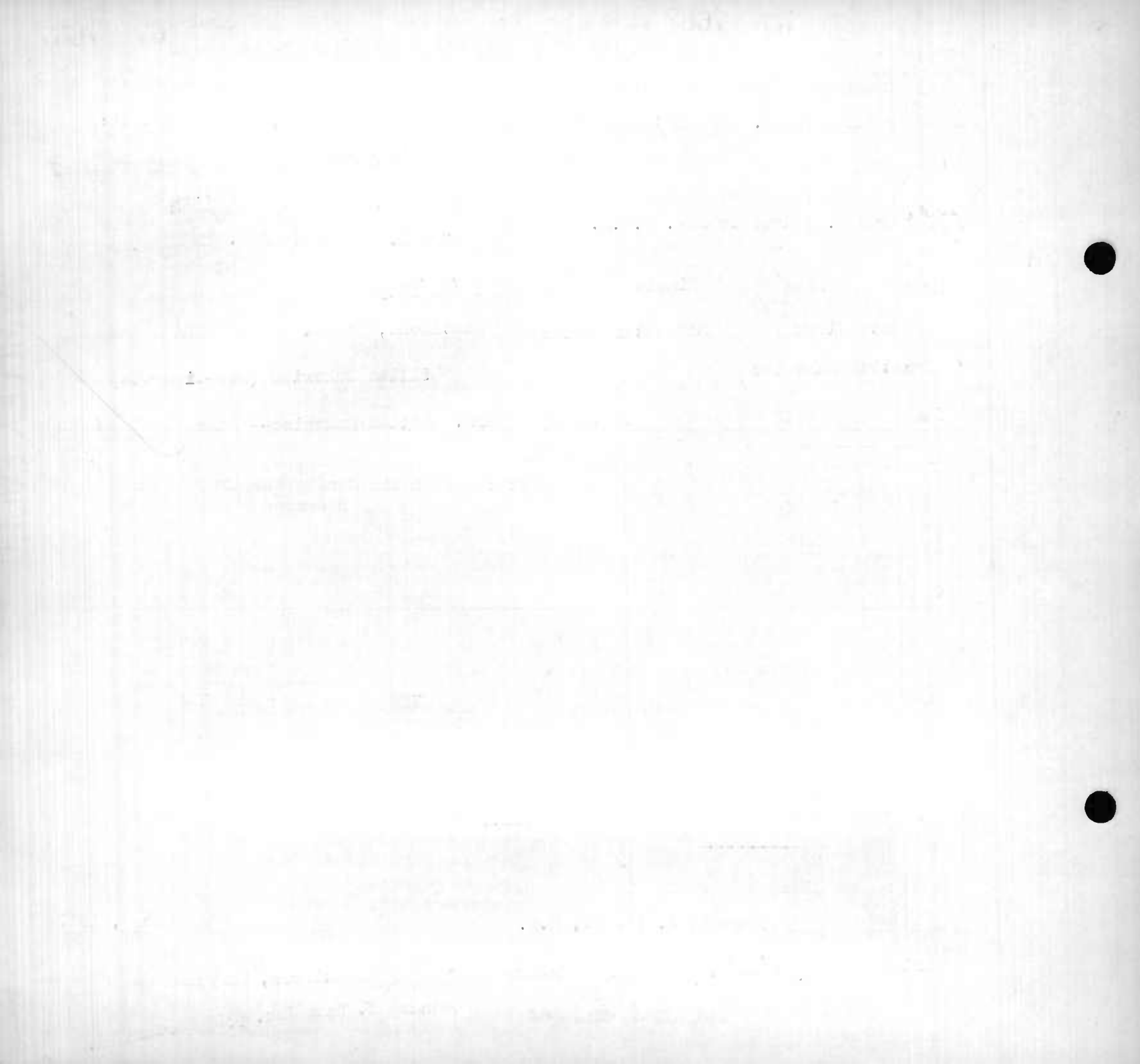
AUG 10 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7668				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 7668	
1. NAME OF DECEASED Charles W. Hamilton <small>(Type or Print)</small>				2. DATE AND HOUR OF DEATH AUGUST 9, 1967 13:35 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL WILKENS AVE AND CATON BALTIMORE MARYLAND 21229 <small>(If not in hospital or institution, give street address and city and county)</small>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) MARYLAND <small>A. STATE B. COUNTY</small> BALTIMORE 21230 <small>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</small> 2023 HARMAN AVENUE 1834 Wilkens Ave. <small>D. STREET ADDRESS (If rural, give location)</small>					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED Married <small>WIDOWED, DIVORCED (specify)</small>	8. DATE OF BIRTH 8/24/86	9. AGE (In years last birthday) 81 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Unknown Hamilton				14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? No <small>(Yes, no or unknown) (If yes, give war or dates of service)</small>				16. SOCIAL SECURITY NO. 213-18-8407		17. INFORMANT ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE			
18. 42001 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> Subendocardial myocardial infarction - severe atherosclerosis and congestive heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute pyelonephritis				CAUSE OF DEATH Subendocardial myocardial infarction - severe atherosclerosis and congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>					
21D. TIME OF INJURY (APPROX.) <small>(Month) (Day) (Year) (Hour)</small>		21E. INJURY OCCURRED <small>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></small>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from AUGUST 9 1967 to AUGUST 9 1967 , that (I) (we) last saw the deceased alive on AUGUST 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. M. M. M.				23B. DATE SIGNED 8/9/67		23C. PHYSICIAN'S NAME (Type) R. M. M. M.			
23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery		24D. LOCATION Front Royal		24E. ADDRESS Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR 4107		25D. ADDRESS Howard H. Hubbard, 4100 Wilkens Ave. 21229			

1955 N.M.

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1955 N.M.

1955 N.M.

67 7669

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7669

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967

7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

231 N. Carey St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

231 N. Carey St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

May 2, 1917

9. AGE (in years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward E. Smith

14. MOTHER'S MAIDEN NAME

Mary Pratt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

218-07-3205

17. INFORMANT

ADDRESS

Nora Brawner 231 N. Carey St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Alteration of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/10/1967

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem Balto. Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. School St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7670				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7670	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SCHROEN, GEORGE Charles				2. DATE AND HOUR OF DEATH 8/8/67		11:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229				A. STATE B. COUNTY MARYLAND 21229			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 306 ORCHARD AVENUE 21225			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-30-08	9. AGE (In years lost birthday) 58	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Brager-Gutman Dept Store		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES Schroen DEC'D				14. MOTHER'S MAIDEN NAME DAISY (ZIMMERMAN) DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NONE		16. SOCIAL SECURITY NO. 216 03 3301		17. INFORMANT ADDRESS 216 03 3301 HOSPITAL RECORDS- ST. AGNES HOSPITAL			
18. 451X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Dissecting aortic aneurysm involving renal art.-s				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Emphysema			
				(C) Conjunctive heart failure			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XI (this hospital) attended the deceased from AUGUST 7, 1967 to AUGUST 8, 1967 , that XI (we) last saw the deceased alive on AUGUST 8, 1967 and that XX (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (X (We) (did) (deceased) view the body after death.							
23A. SIGNATURE S Korbuly M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 8-9-67	
23C. PHYSICIAN'S NAME (Type) S KORBULY M.D.				23D. ADDRESS CATON & WILKENS AVE BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/1/2/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Howard Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR McCall's Funeral Home		ADDRESS Patapsco & 3rd St. Brooklyn 21225	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

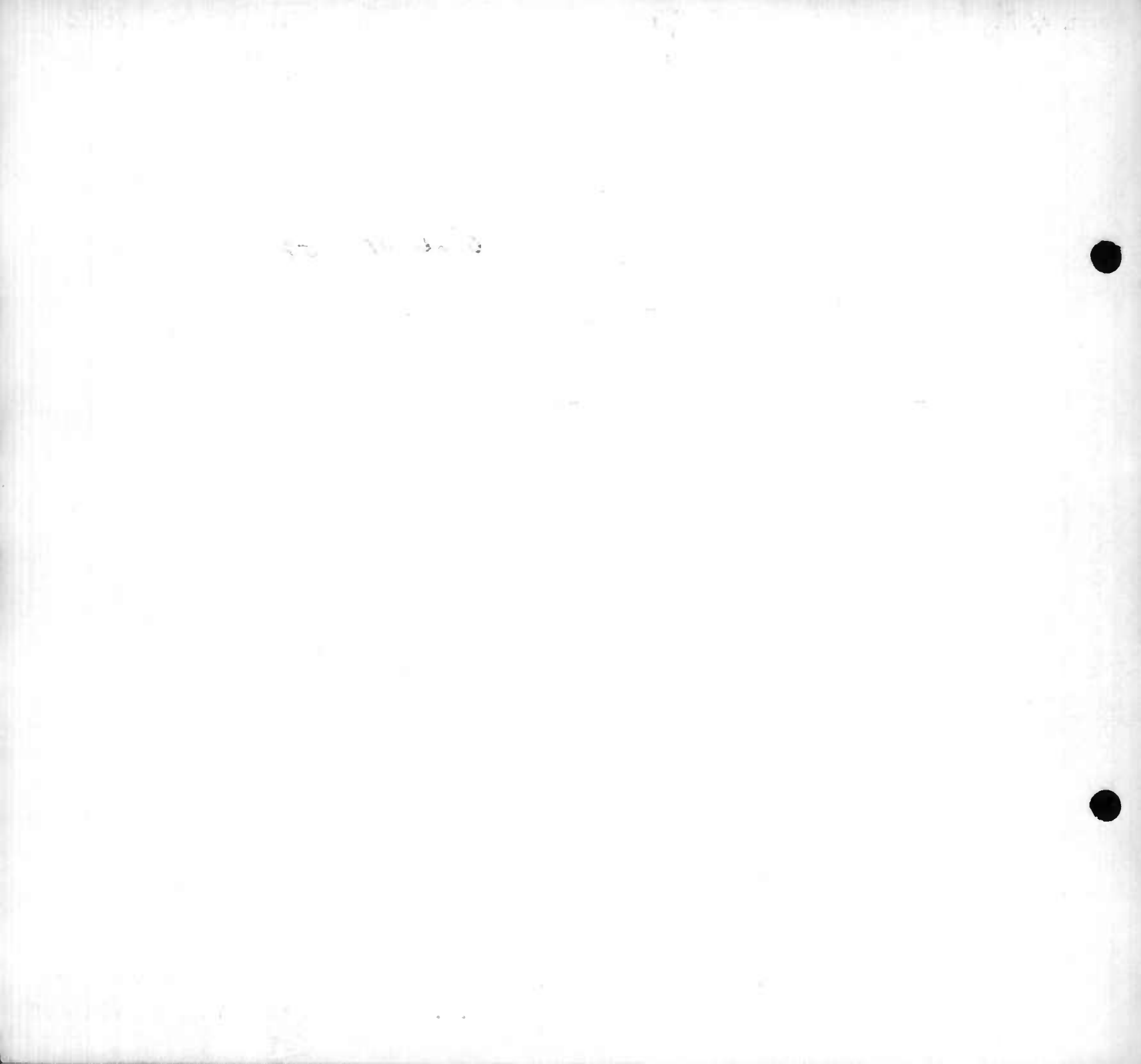
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7671	
BIRTH NO. N-425-42067 7671		CERTIFICATE OF DEATH	
M.E. CASE NO. N-42067		1. NAME OF DECEASED (Type or Print) NIELSON, LINDA W. (WALKE)	
2. DATE AND HOUR OF DEATH 11:25 AM Aug 9, 1967		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RIDERWOOD	
D. STREET ADDRESS (If rural, give location) P O BOX # 1		5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	
8. DATE OF BIRTH 11-5-08 9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Sales	
11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ISAAC T. WALKE		14. MOTHER'S MAIDEN NAME LINDA HARRELL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-2213	
17. INFORMANT: son & daughter Linda W. McLanahan, Riderwood, Balto. Co., Md.		ADDRESS J. Craig McLanahan, Boston, Mass.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Malignancy (LUNG)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from Aug 8 19 67 to Aug 9 19 67 , that (I) (we) last saw the deceased alive on Aug 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ronald E. Smith M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED Aug 9, 1967		23C. PHYSICIAN'S NAME (Type) RONALD E. SMITH	
23D. ADDRESS JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION	
24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY Green Mount Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967	
25B. NAME OF REGISTRAR R. E. Farley, Md.		25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av. City	

REPRODUCTION
1922

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

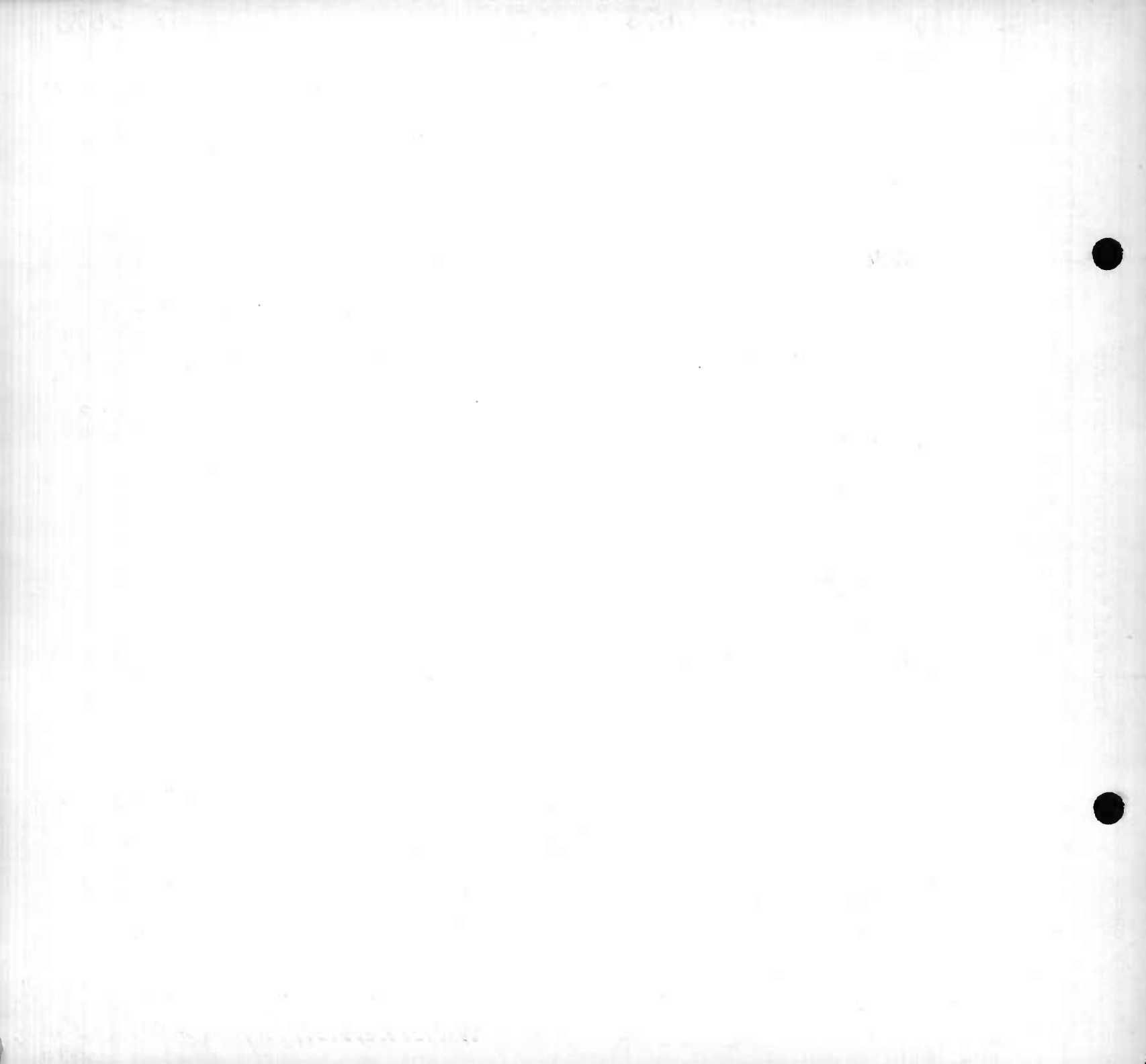
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7672	
BIRTH NO. 67 7672		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELEN TELLJOHANN		2. DATE AND HOUR OF DEATH Aug. 9, 1967 5:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 5 Church Home & Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4701 Ellison Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/26/09	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edmund J. Zacharski		14. MOTHER'S MAIDEN NAME Julia Hoppe		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 220-22-1776		17. INFORMANT Janice Morawski	
18. 3810 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hepatic Insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Partial cirrhosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Hepatic Insufficiency DUE TO (B) Partial cirrhosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 6 19 67 to Aug. 9 19 67 , that (I) (we) last saw the deceased alive on Aug. 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adams				23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) NONITA SUAREZ		23D. ADDRESS Church Home & Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67		24C. NAME of CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967			
25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7673		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 7673	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Martha Armstrong</i>		2. DATE AND HOUR OF DEATH <i>8/8/67</i> <i>8:05 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Lincoln Nursing Home.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>15-38</i> D. STREET ADDRESS (If rural, give location) <i>2503 Elsinore.</i>					
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>8/12/20</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Thomas Armstrong</i>				14. MOTHER'S MAIDEN NAME <i>Annie Elizabeth Curtis</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mary Clarke Avenue, Md.</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <i>171 X I</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Carcinoma of Uterine Cervix.</i> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No.</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>5th July</i> 19 <i>67</i> to <i>8th Aug</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>8th Aug</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Alvin Thompson</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/8/67.</i>			
23C. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i>				23D. ADDRESS M.D. <i>1856 N. Wolfe St. Balto.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/11/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>		24D. LOCATION (City, town, or county) (State) <i>Bushwood, St Mary's, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Md.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>W. Clarke Mattingley Leonardtown, Md.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7674				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7674	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lucie Davenport Peddicord				2. DATE AND HOUR OF DEATH 10 Aug 67 1 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND The Wesley Home FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2211 W. Rogers Ave				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave.			
5. SEX F		6. RACE Cauc.		7. MARRIED, NEVER MARRIED WIDOWED (specify)		8. DATE OF BIRTH 6-10-1876	
9. AGE (In years lost in day) 91		10. UNDER 1 Yr. Months Days 1 A		11. UNDER 24 Hrs. Hours Min. 1 A		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME William H. Davenport				14. MOTHER'S MAIDEN NAME Maria Isabella Eustace Isabelle E. Eustace			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Virginia Lee Peddicord, Baltimore, Md. 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.8 I Carcinoma colon				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 20 Aug 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma colon		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 16 July 1966 to 10 Aug 1967 , that (I) (we) last saw the deceased alive on 8 Aug 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John W. Barnaby				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11 Aug 67	
23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby				23D. ADDRESS 1530 E. North Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 12, 67		24C. NAME of CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Farley, Md		25C. FUNERAL DIRECTOR Wm Cook-Brooks-Twinn		ADDRESS 1050 York Rd.	

8/16/67 - Correction form from funeral director.

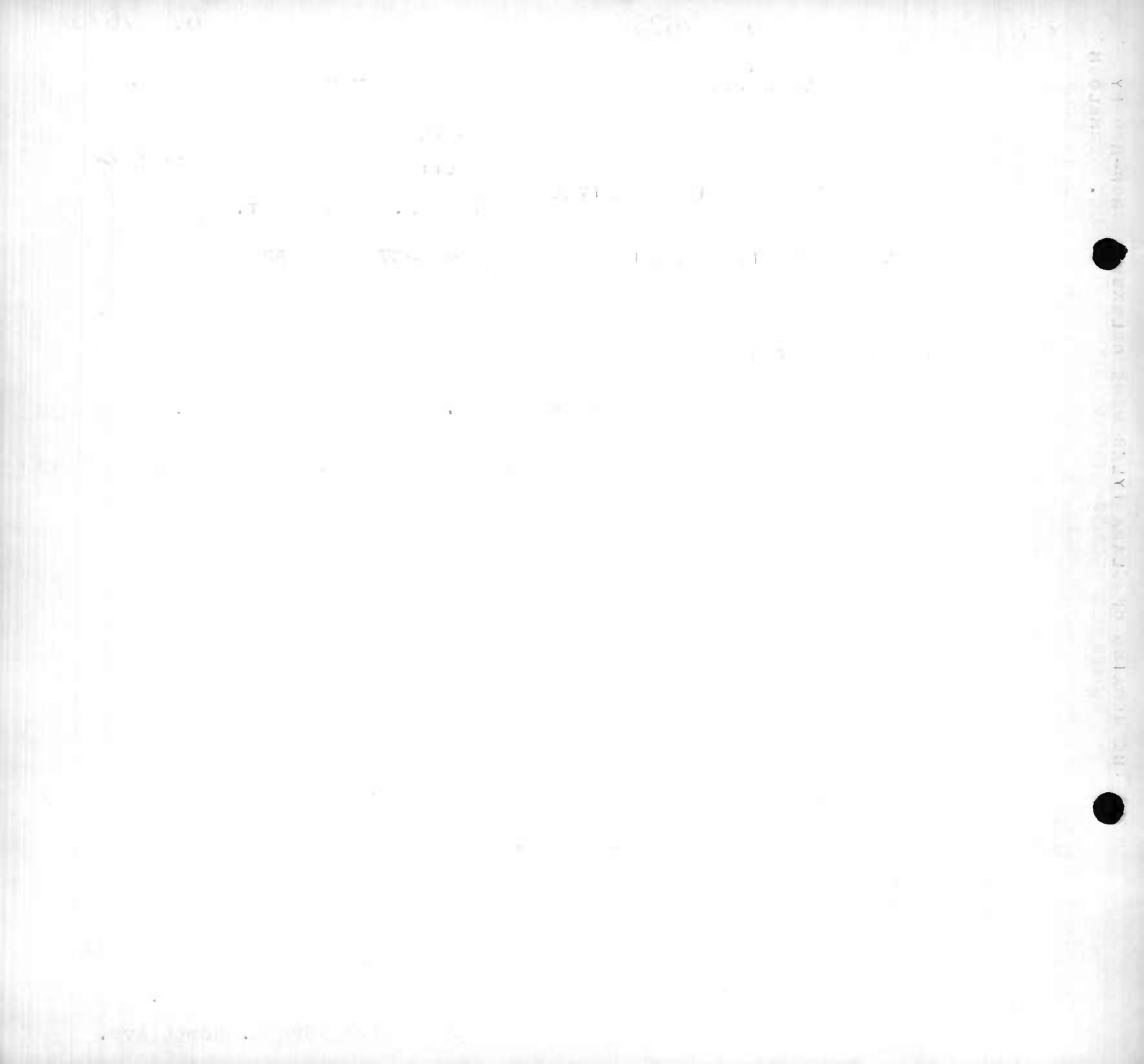
LFC.

THE REMAINS OF CLARA TYLER WERE RELEASED
FUNERAL DIRECTOR: IMPORTANT

NON-MED BY
DR. KORMBLOOM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 7675	
BIRTH NO. 67 7675											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) B. CLARA TYLER						2. DATE AND HOUR OF DEATH 8-9-67 4:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
						D. STREET ADDRESS (If rural, give location) 1431 E. FEDERAL ST.					
5. SEX FEMALE		6. RACE NEGROID		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 11-27-07		9. AGE (In years last birthday) 59		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS HAMPTON						14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-32-4095		17. INFORMANT Mr. Ernest Tyler				ADDRESS 1431 E. Federal St	
18. 330X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Subarchnoid Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 5 hrs											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 1230p 8/9 1967 to 425pm 8/9 1967 that (I) (we) last saw the deceased alive on 8/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE G. Michael Vincent M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED 8/9/67			
23C. PHYSICIAN'S NAME (Type) G. MICHAEL VINCENT M.D.						23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/13/67		24C. NAME OF CEMETERY or CREMATORY Charles City, Va.				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967				25B. NAME OF REGISTRAR Robert E. Seligman				25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7676	
BIRTH NO. 67 7676		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) OZERBELL, LEE		2. DATE AND HOUR OF DEATH 8-9-67 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1813 E. North Ave			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) WIDOW	8. DATE OF BIRTH 12-4-1909	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME GRANT HARRIS		14. MOTHER'S MAIDEN NAME SARAH HARRIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Herman Lee 2707 E. Hoffman St.		
18. 17510 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Ovarian Carcinoma		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ? Dx April 1967	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from August 7, 1967 to August 9, 1967 , that (I) met last saw the deceased alive on August 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Richard MoFazzoli M.D.				23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) Richard MoFazzoli M.D.				23D. ADDRESS The Johns Hopkins Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

LOVELACE

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1967

2:18 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1051 N. Central Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1051 N. Central Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Jan. 15, 1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Natalia, Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Lovelace

14. MOTHER'S MAIDEN NAME

Bettie Ballou

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war and dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Virginia Lovelace

V.A.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Thompson's Patent
No. 1000000
1870

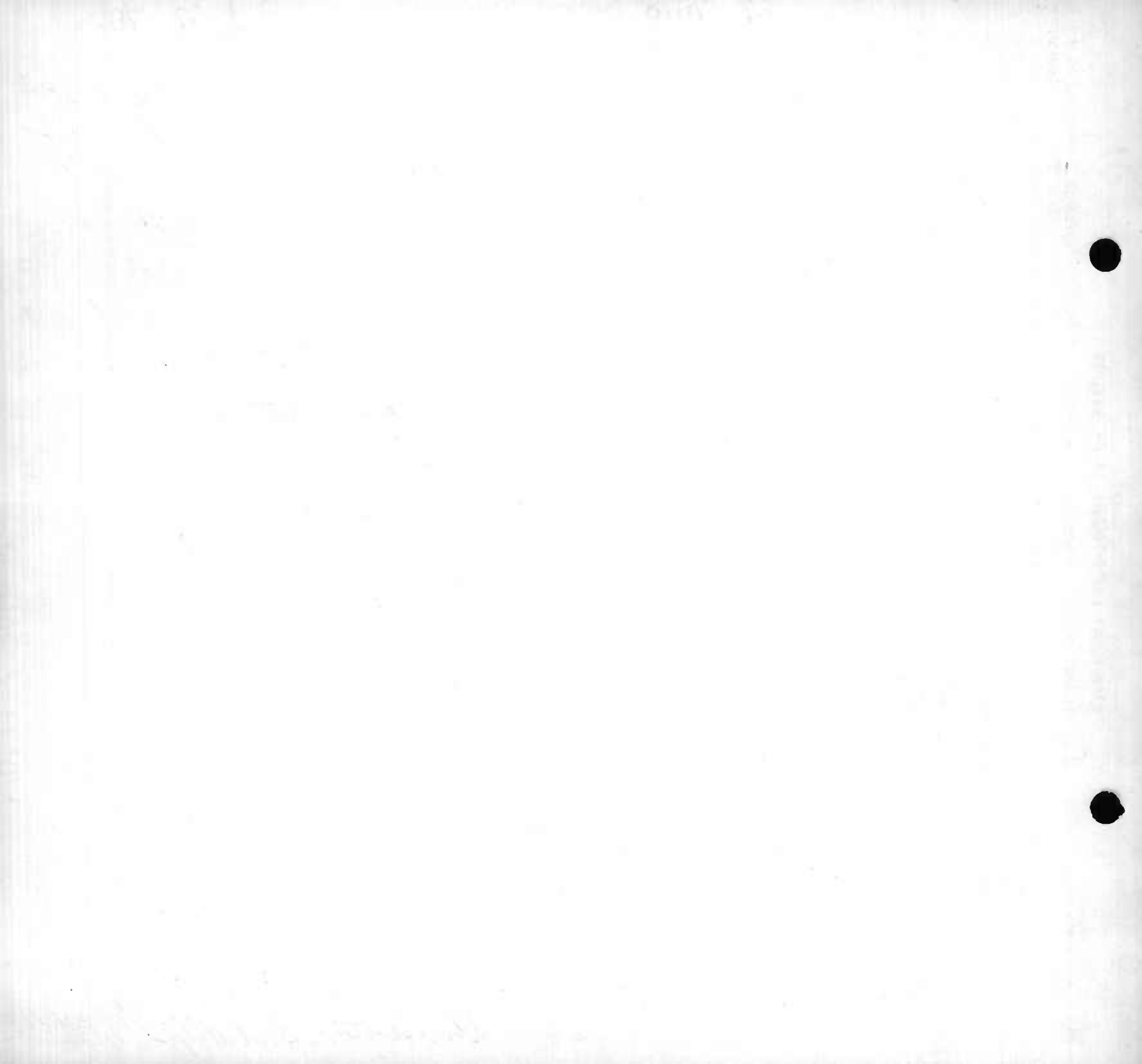
1870

Thompson's Patent
No. 1000000
1870

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

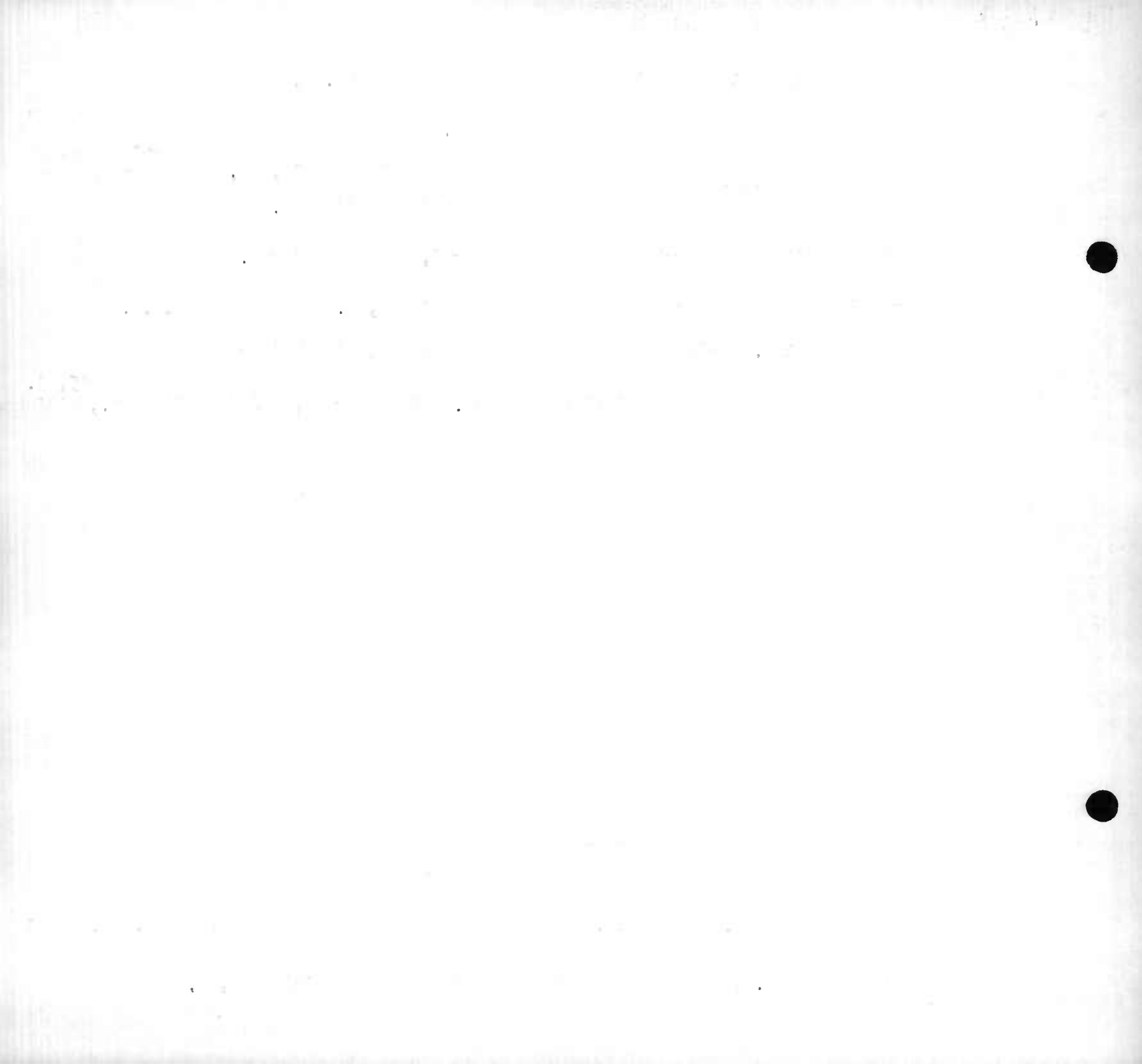
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 7678	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wanda R. Whiting</i>		2. DATE AND HOUR OF DEATH <i>August 6, 1967 2:20 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Singi Hospital of Baltimore, Inc.</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>3920 Greenspring Ave.</i>			
5. SEX <i>F.</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>		8. DATE OF BIRTH <i>10/26/56</i>	9. AGE (In years, lost birthday) <i>10</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elementary School Student</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fred Whiting Jr.</i>				14. MOTHER'S MAIDEN NAME <i>Barbara Sherman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mother - Barbara Whiting</i>		ADDRESS <i>Same</i>	
18. <i>330X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Intracerebral Hemorrhage</i> DUE TO (B) <i>Congenital Vascular Lesion</i> DUE TO or (C) <i>Berry Aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH <i>40 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>7/4/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Increased Intracranial Pressure</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No.</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>August 5 1967</i> to <i>August 6 1967</i> , that (I) (we) last saw the deceased alive on <i>August 6 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. Meyer Heller</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>August, 1967</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Singi Hospital of Baltimore, Inc.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. Co. Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>		25C. FUNERAL DIRECTOR <i>William Phillips</i>		ADDRESS <i>1727 N. ...</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 7679					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 7679				
1. NAME OF DECEASED (Type or Print) Annie Castleman Holdson					2. DATE AND HOUR OF DEATH Aug. 7, 1967				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital					A. STATE Md.				
(If not in hospital or institution, give street address or location)					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and township) Baltimore 15, Md.				
					D. STREET ADDRESS (If rural, give location) 5256 Cordelia Ave.				
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH May 6, 1891		9. AGE (In years last birthday) 76 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert S. Davis					14. MOTHER'S MAIDEN NAME Hanna Marie Shriver				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-10-6594		17. INFORMANT Mrs. Esther Seward, 5256 Cordelia Ave., Baltimore 15, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420, I					CAUSE OF DEATH Acute Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH Sudden Death	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO A. S. I. D.			(B) DUE TO About 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Herpes Zoster 2) Pneumonitis, Rpt 12 ago								About 2 months About 3 weeks	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/12/61 19 to 8/6/67 19, that (I) (we) lost saw the deceased alive on 7/31/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Julius C. Gluck					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>			23B. DATE SIGNED 8/8/67	
23C. PHYSICIAN'S NAME (Type) Julius C. Gluck, M.D.					23D. ADDRESS 5356 Reisterstown Road, Balto. Md. 21215				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 9, 1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR Frank H. Newell			ADDRESS Pitersville	

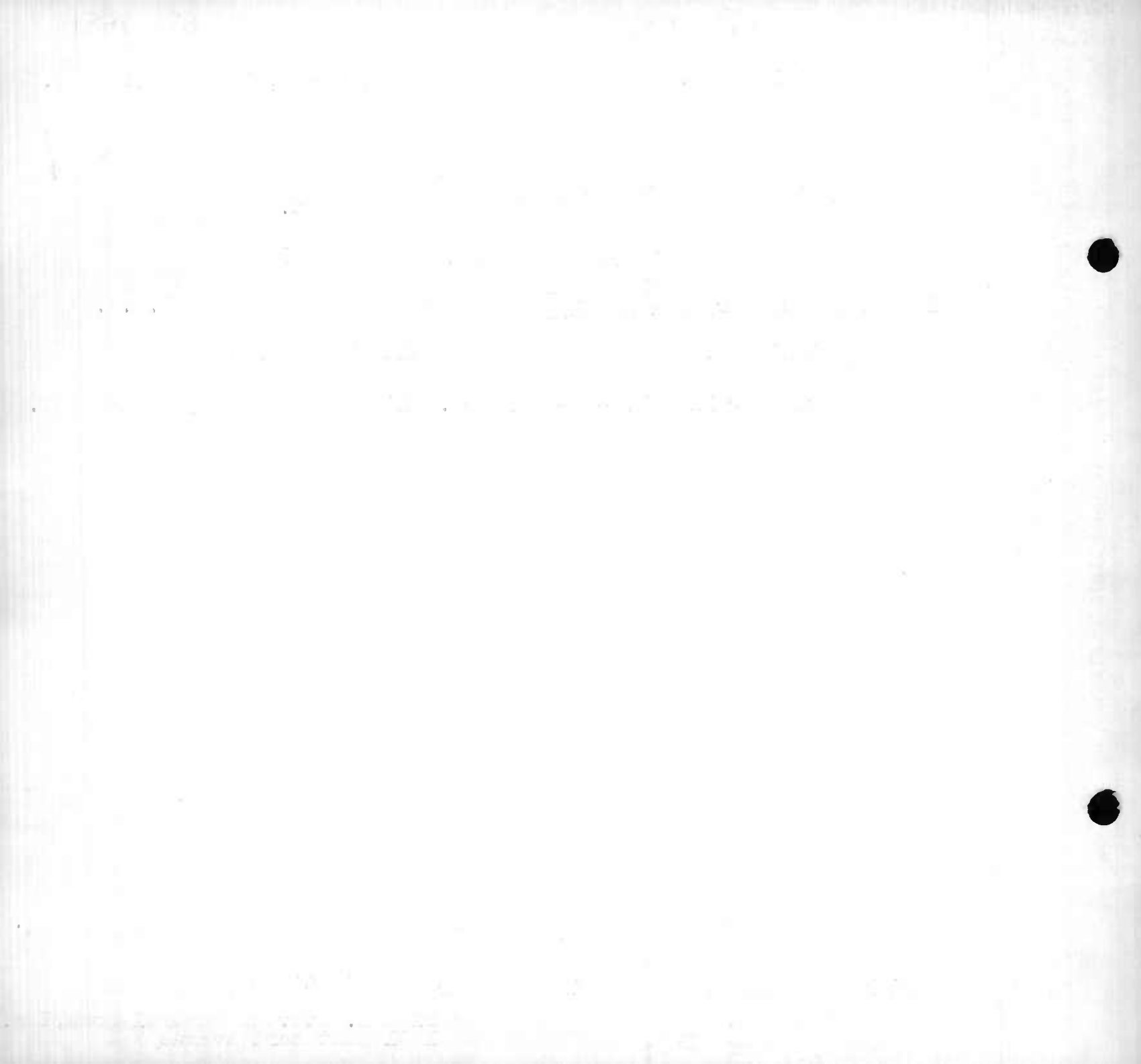


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7680		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 7680	
1. NAME OF DECEASED (Type or Print) FRANCIS R. BARTEE				2. DATE AND HOUR OF DEATH Aug 8-10-67 6:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (FRANCIS R. BARTEE)				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). A. STATE Maryland B. COUNTY 23-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230			
D. STREET ADDRESS (If rural, give location) 1044 So. Charles St.							
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 6-26-08	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter -		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Frankfort, Ky -		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Bartee				14. MOTHER'S MAIDEN NAME Cora Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 302-10-0392		17. INFORMANT Donita L. Wyatt-Jenson		ADDRESS 942 - Beaverbank Circle, Balto. Md 21204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intestinal Obstruction				CAUSE OF DEATH (A) DUE TO Renal Shut down		INTERVAL BETWEEN ONSET AND DEATH 25 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Marked Hypoproteinaemia - 2 months Post-Operative gastric ulcer				(B) DUE TO Marked Hypoproteinaemia - 2 months Post-Operative gastric ulcer			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 7-20 19 67 to 8-10 19 67 , that (we) last saw the deceased alive on 8-10 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Abdul G. Qureshi				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-67	
23C. PHYSICIAN'S NAME (Type) ABDUL G. QURESHI				23D. ADDRESS SBGH Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 12 1967		24C. NAME OF CEMETERY or CREMATORY Greenwood Cemetery		24D. LOCATION (City, town, or county) (State) Glenn Beach Md 21061	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR CURTIS E. EVANS		ADDRESS 1400 S. CHARLES ST BALTO MD 21206	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7681				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 7681	
1. NAME OF DECEASED (Type or Print) William J. Keen				2. DATE AND HOUR OF DEATH August 9, 1967 7:40 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-01 D. STREET ADDRESS (If rural, give location) 1438 Towson St.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 1/6/1914	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financial Secretary Local # 193				10B. KIND OF BUSINESS OR INDUSTRY Boilermakers		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Keen				14. MOTHER'S MAIDEN NAME Elizabeth Helder					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 178-10-2119		17. INFORMANT ADDRESS Mrs. Elizabeth Keen 1438 Towson St.					
18. I 63 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Terminol lungs Ca ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1967 to Aug 9 19 67 , that (I) (we) last saw the deceased alive on Aug 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Stanley Ankudras				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8.11.67			
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDRAS				23D. ADDRESS 1101 Maiden Choice Ln, Beach 21222					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue					



FUNERAL DIRECTOR: IMPORTANT

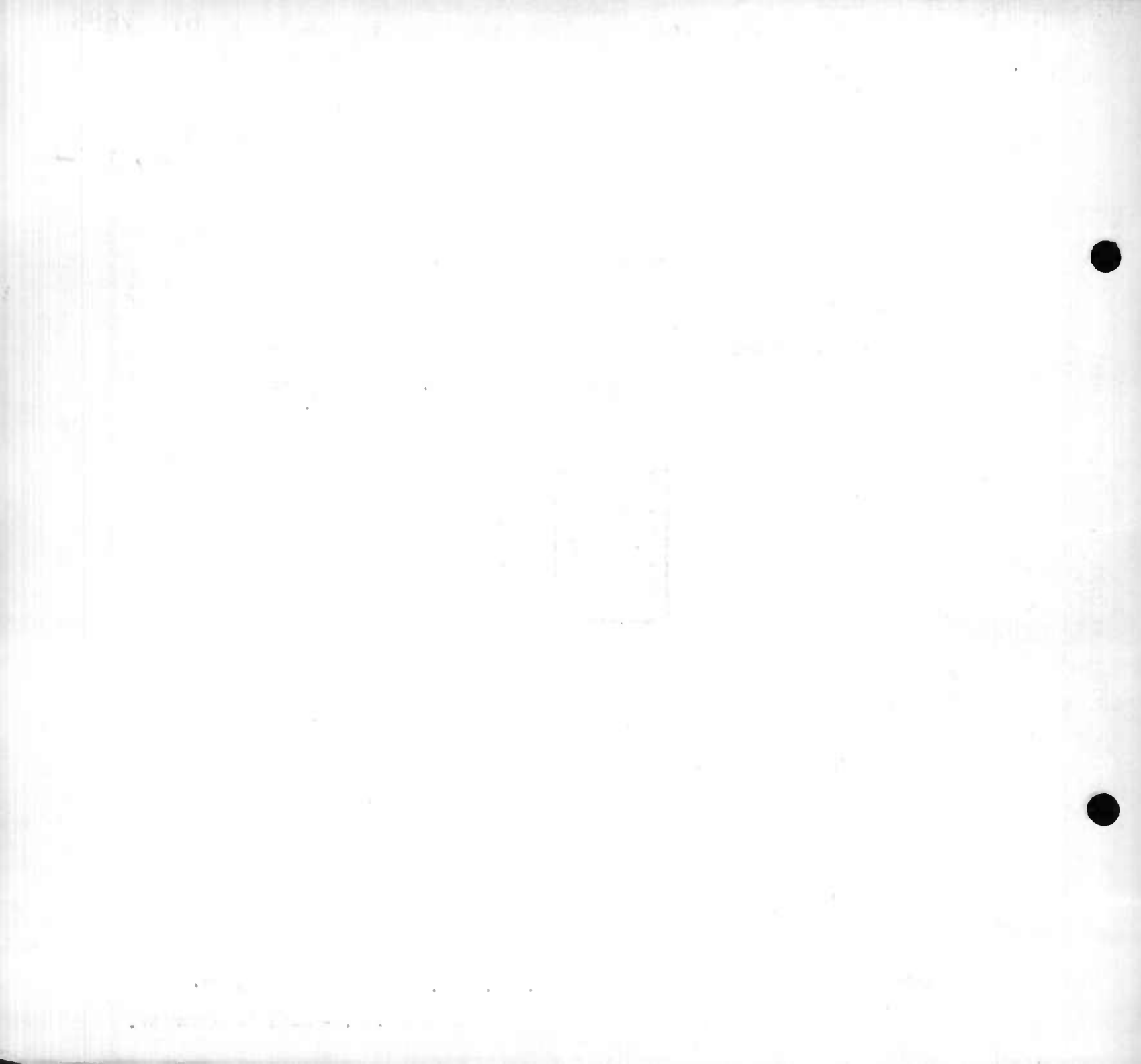
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7682				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7682	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Darnella Niles</i>				2. DATE AND HOUR OF DEATH <i>7/28/67</i> <i>8:10</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Geo. Wash. Carver Nursing Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
90 <i>607 Penn. Ave</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		D. STREET ADDRESS (If rural, give location) <i>4940 Eastern Ave. C.C. Hospital</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>5-27-1885</i>		9. AGE (In years last birthday) <i>82</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-54-1320</i>		17. INFORMANT <i>Chart</i>		ADDRESS	
18. <i>4-20-11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Coronary occlusion - acute</i> DUE TO (B) <i>Cerebral Arterio-sclerosis</i> DUE TO (C) <i>Chronic Brain Syndrome</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i> <i>Unknown</i> <i>Unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>2/16</i> 19 <i>66</i> to <i>7/28</i> 19 <i>67</i> , that (I) <i>lost</i> saw the deceased alive on <i>7/27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E.E. Holt</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/1/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E.E. Holt</i>				23D. ADDRESS M.D. <i>3715 Liberty Hts. Ave., Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burned</i>		24B. DATE <i>8/6/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>MA. Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Ches. Burial Monument</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>John Carroll</i>		ADDRESS <i>1712 W. North Ave</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

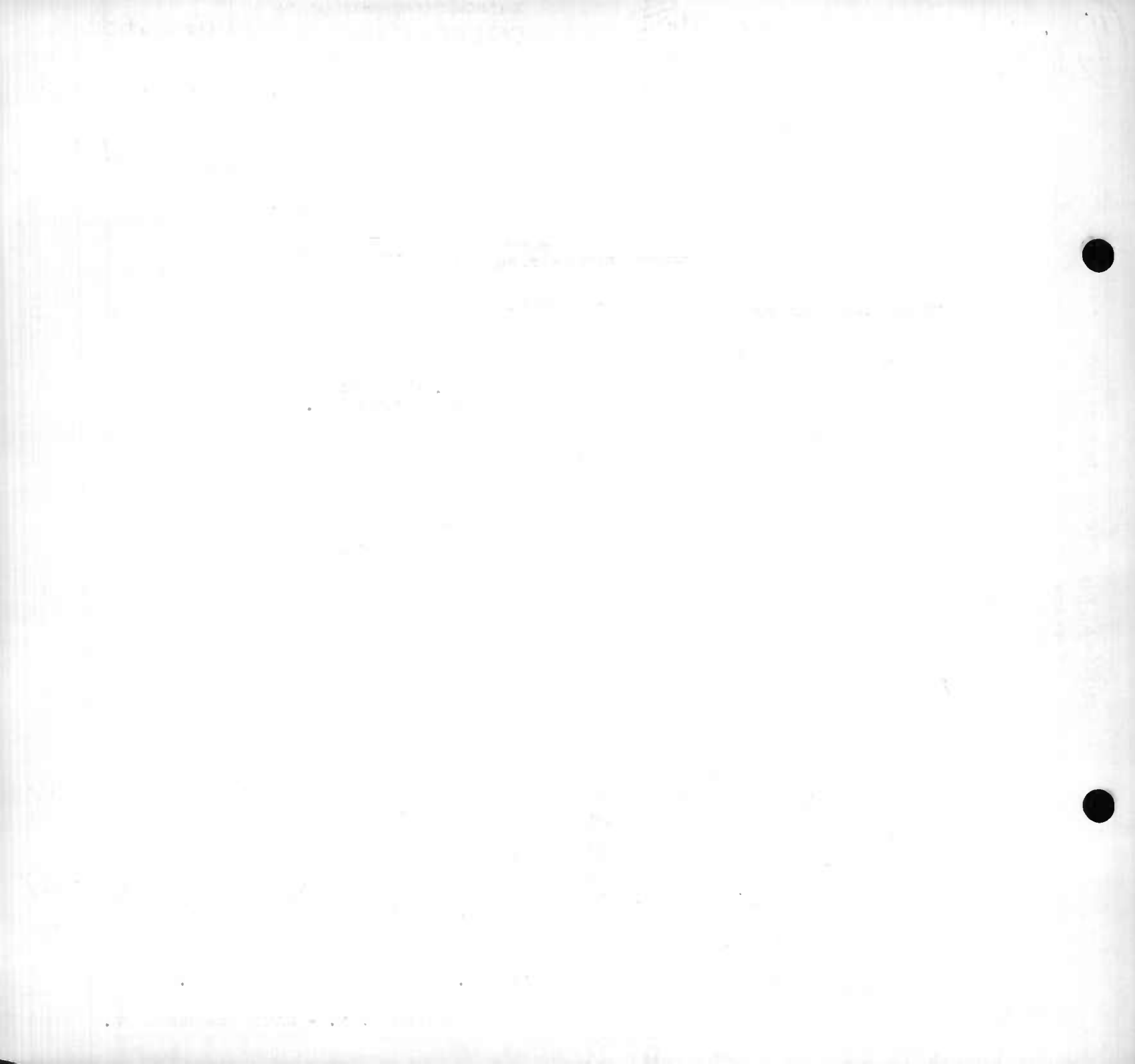
BIRTH NO. 67 7683		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7683	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Elizabeth Fouts</i>			2. DATE AND HOUR OF DEATH <i>8-8-67 3:15 P M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 HOUSE IN PINES 2525 W. Belvedere</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balls</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>28-04</i> D. STREET ADDRESS (If rural, give location) <i>4421 Rokeby Rd</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2/22/81</i>	9. AGE (in years lost birthday) <i>86</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Indiana</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Festus Lindsay</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Vorhees</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Mrs. Ester Buehler 4421 Rokeby Rd.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Coronary Heart Disease arterio sclerosis Senility</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<i>Broken Rt hip. July 4th 1967</i>		
19A. DATE OF OPERATION <i>7/7/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Rt Hip</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>4421 Rokeby Rd</i>		21C. WHERE DID INJURY OCCUR? <i>4421 Rokeby Rd Balls md</i>	
21D. TIME OF INJURY (APPROX.) <i>7/4/67 Pm</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>accidentally fell & broke Rt hip while on patio of her home</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>July 4</i> 1967 to <i>Aug 8</i> 1967, and that (I) (we) last saw the deceased alive on <i>Aug 8</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M Paul Byerly</i>			23B. DATE SIGNED <i>8/8/67</i>		
23C. PHYSICIAN'S NAME (Type or Print) <i>M Paul Byerly</i>			23D. ADDRESS <i>5820 York Rd Balls 2122 md</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/11/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Pk. Cem.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1967</i>		24F. NAME OF REGISTRAR <i>Robert E. Fasham</i>	
24G. FUNERAL DIRECTOR <i>Witzke F. D.</i>		24H. ADDRESS <i>4101 Edmondson Av.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

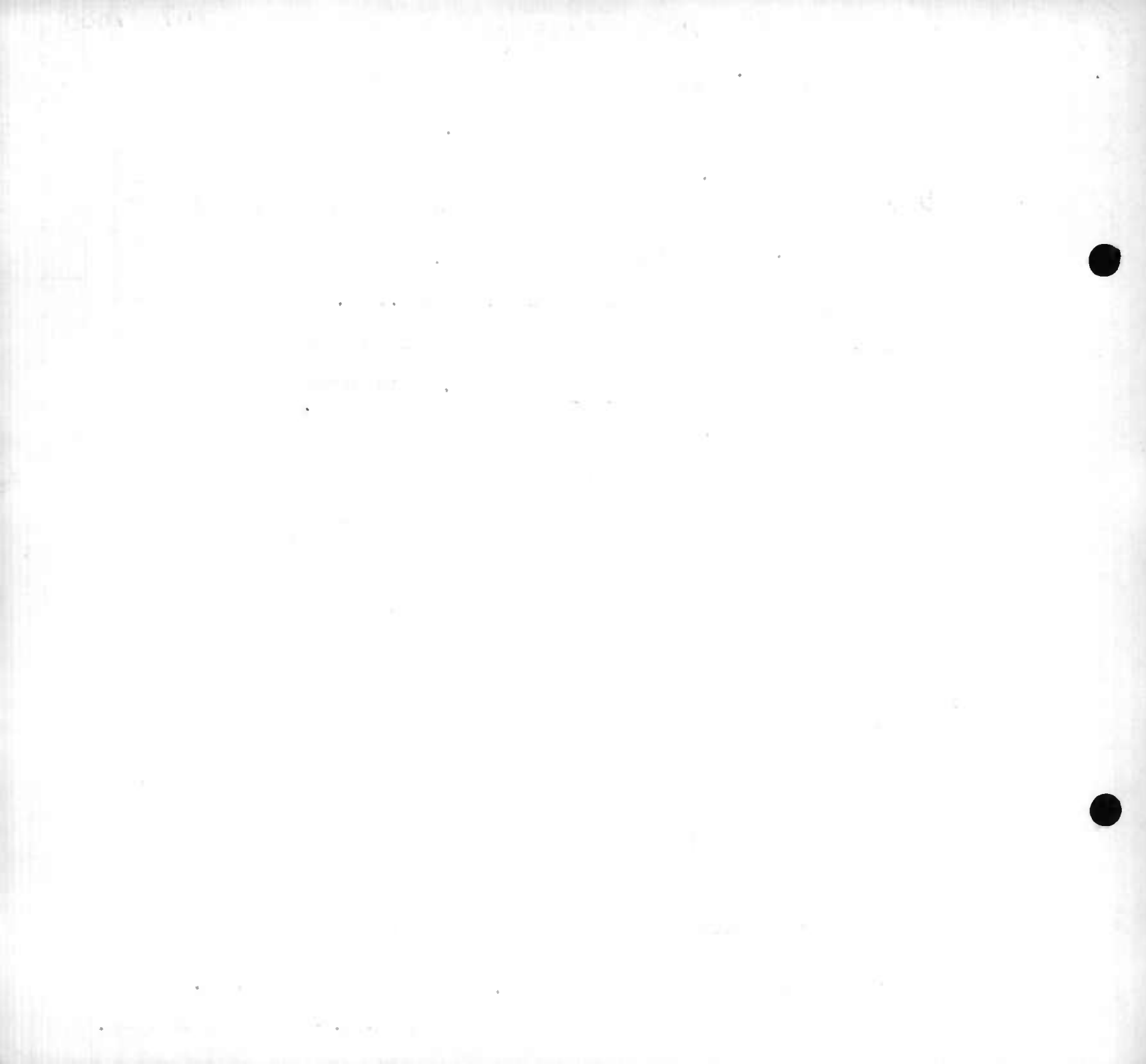
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7684	
67 7684				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		ANTHONY S. LEO		Aug 9, 1967 10:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL 37 BALTO. MD.		A. STATE MD		B. COUNTY BALTO.	
5. SEX M		6. RACE W		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Never Married)		8. DATE OF BIRTH 10/23/14		9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER Manager		Mars Super Market		MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK LEO		14. MOTHER'S MAIDEN NAME SANTA FARACE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN				Mr. John Leo 6607 Marne Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X I		BILATERAL PNEUMONIA			
ANTECEDENT CAUSES		GANGRENE (R) LEG			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		DIABETES MELLITUS			
II		ARTERIO-SCLEROTIC CARDIOVASCULAR DIS.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		8/5/67		GANGRENE (R) LEG	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2 August 1967 to 9 August 1967, that (I) (we) last saw the deceased alive on 9 August 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jeffrey S. Stier M.D.				9 August 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JEFFREY S. STIER				MERCY HOSPITAL, BALTO, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/12/67		New Cathedral Cem.	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Md.		AUG 11 1967		Witzke F. D.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				Witzke F. D. - 4101 Edmondson Av.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7685	
BIRTH NO. 67 7685		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Marjorie E. Ehman	
2. DATE AND HOUR OF DEATH 8-9-67 1640 P. M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4944 Lindsay Rd.	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 4944 Lindsay Road		5. SEX F	
6. RACE Cauc.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH Apr. 26/21		9. AGE (In years last birthday) 46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn Co. Balto., Md.	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - John Gilliss		14. MOTHER'S MAIDEN NAME Edna Martin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-0960	
17. INFORMANT Mr. Edgar Ehman		ADDRESS 4944 Lindsay Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Carcinoma of breast		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Lung, brain and bone metastases			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-7-1967 to 8-9-1967 , that (I) (we) last saw the deceased alive on 8-9-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Barbu Calin		23B. DATE SIGNED 8-10-67	
23C. PHYSICIAN'S NAME (Type) Barbu Calin		23D. ADDRESS 8811 Liberty Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67	
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1967		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Witzke F. D.		ADDRESS 4101 Edmondson Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7686

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
WILLIE

ALEXANDER

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1967

2:33 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1127 S. Sharp Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

WILLIE ALEXANDER

14. MOTHER'S MAIDEN NAME

EMMA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

(MOTHER) ADDRESS

EMMA ALEXANDER 1600 EDMONDSON AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Hanover and Cromwell Sts. 23-03

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8/8/67 2:10 A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. driver of car -
collided with a telephone pole.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-11-1967

23C. NAME OF CEMETERY or CREMATORY

BALTO NAT'L Cem

23D. LOCATION

(City, town, or county)

BALTO. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

I.L. Brown & Son 123 W. MONTGOMERY ST.

ADDRESS

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EMMA

WILLIE ALEXANDER

(Mother)

Emma Alexander

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7687

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHRISTINE

ALLEN

2. DATE AND HOUR PRONOUNCED DEAD

August 10, 1967

4:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Rosewood State Hospital

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

July 25, 1951

9. AGE (In years last birthday)

16

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

Roland Allen

14. MOTHER'S MAIDEN NAME

Norma Purnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Norma Allen, Stockton, Md.

18. E 921.7

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO

laryngeal obstruction by foreign body (Hot Dog)

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Mental Deficiency

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rosewood State Hospital

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute)

August 10, '67 4:00 P.

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Subj. choked on a hot dog

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

8/11/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Aug. 13, 1967

23C. NAME of CEMETERY or CREMATORY

Home Benef. Cem.

23D. LOCATION (City, town, or county)

Stockton, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

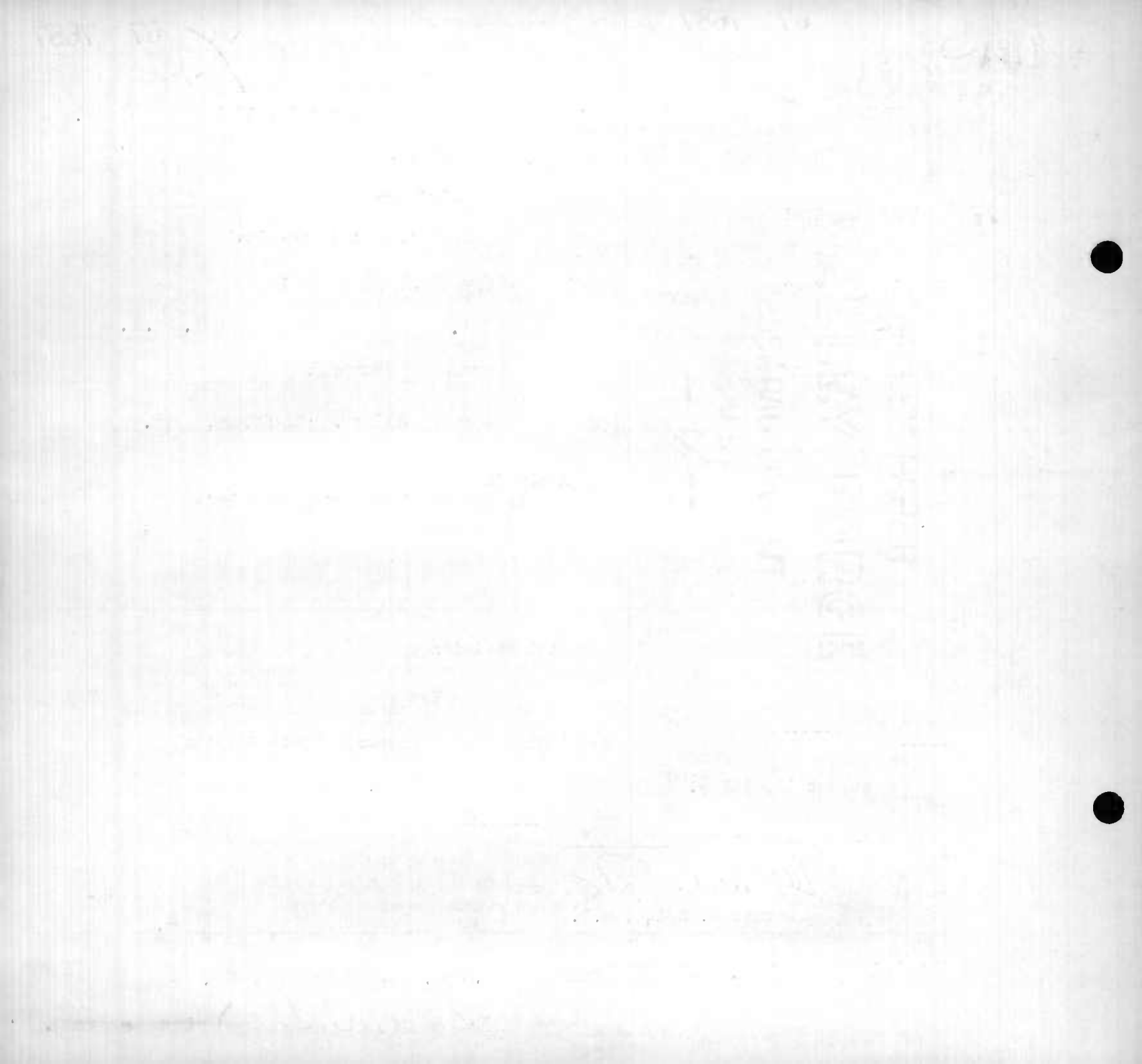
ADDRESS

AUG 11 1967

Robert E. Farkas

Darius W. Long

Princess Anne Md.



FUNERAL DIRECTOR: IMPORTANT

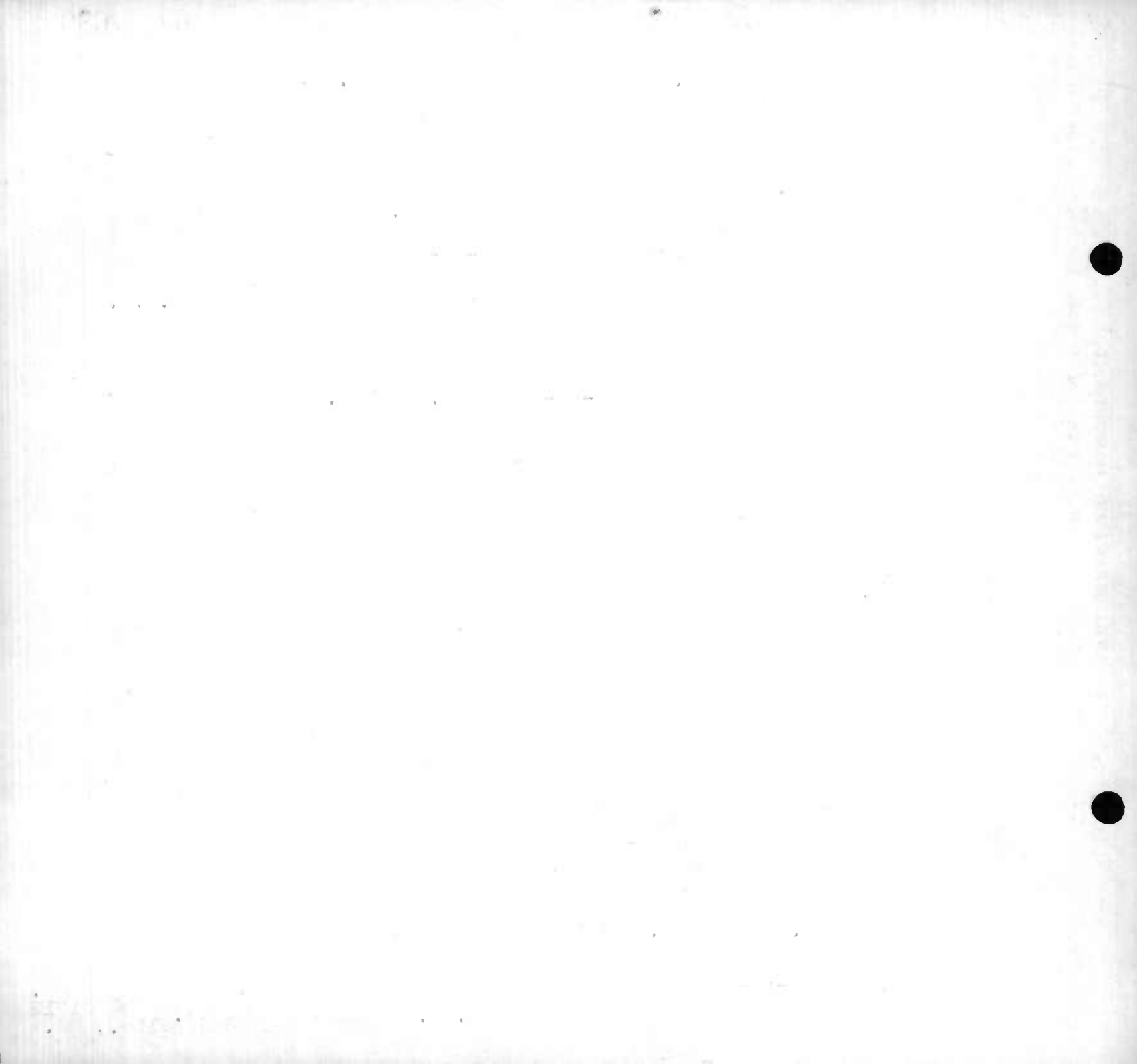
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7688					Registered No. 67 7688				
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Hellen, HALVOR H.</u>					2. DATE AND HOUR OF DEATH <u>8/9/67</u> <u>3 55</u> A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>					A. STATE <u>MARYLAND</u> B. COUNTY <u>Calvert Co</u>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>SOLOMONS</u> <u>54-00</u>				
D. STREET ADDRESS (If rural, give location) <u>(rural)</u>									
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>		B. DATE OF BIRTH <u>11-08-84</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Solomons, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. HELLEN</u>					14. MOTHER'S MAIDEN NAME <u>ELIZABETH HARWARD</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-01-5717A</u>		17. INFORMANT ADDRESS <u>William H. Hellen, Carlisle, Pa.</u>			
18. <u>200.1 I</u>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO <u>Lymph sarcoma</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C) <u>W. K. Allen</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <u>August 6</u> 19 <u>67</u> to <u>August 9</u> 19 <u>67</u> , that (I) was last saw the deceased alive on <u>August 9</u> 19 <u>67</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.									
23A. SIGNATURE <u>W. H. Oehlert, Jr.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>8/9/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM H. OEHLERT, JR., M.D.</u>					23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 11, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Paul's Methodist Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Lusby, Calvert Co., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>A. A. Harkness & Son, Port Republic, Md.</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

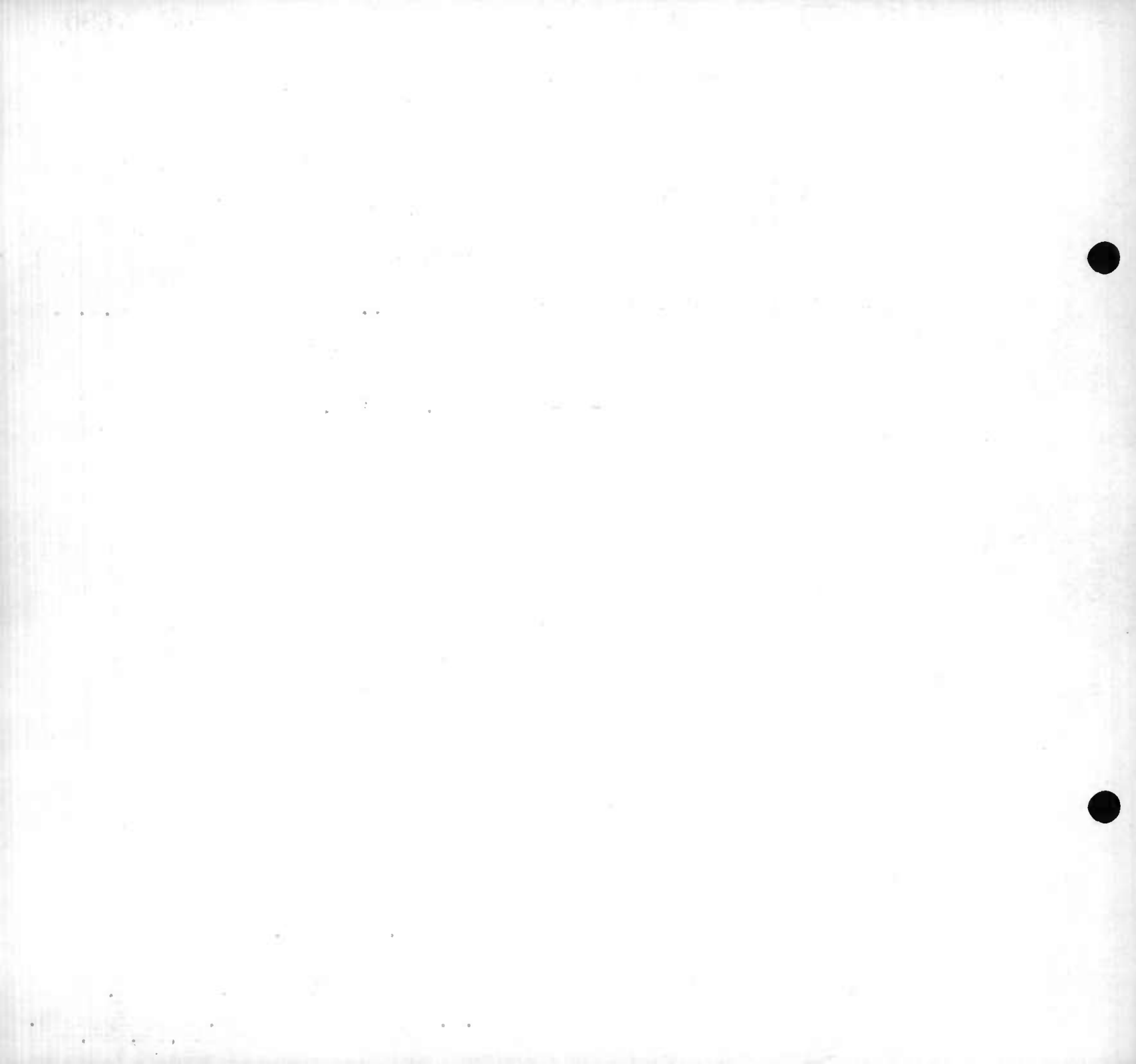
BIRTH NO. 67 7689				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7689	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Mathilde V. Nitze			
2. DATE AND HOUR OF DEATH Aug. 9, 1967 15:00 P M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3900 N. Charles Street				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 3900 N. Charles Street			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 9-18-1887	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hermann Vietor				14. MOTHER'S MAIDEN NAME De Branu			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-48-8106		17. INFORMANT Mr. Carl L. Nitze		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 491X I CAUSE OF DEATH (A) <i>Baccho-pneumonia</i> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 36 hrs.				19. DATE OF OPERATION 1951			
19A. DATE OF OPERATION 1951				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pterocoeosis, generalized			
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ Aug 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W. G. Helfrich</i>				M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug. 10, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich				23D. ADDRESS 5006 Roland Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

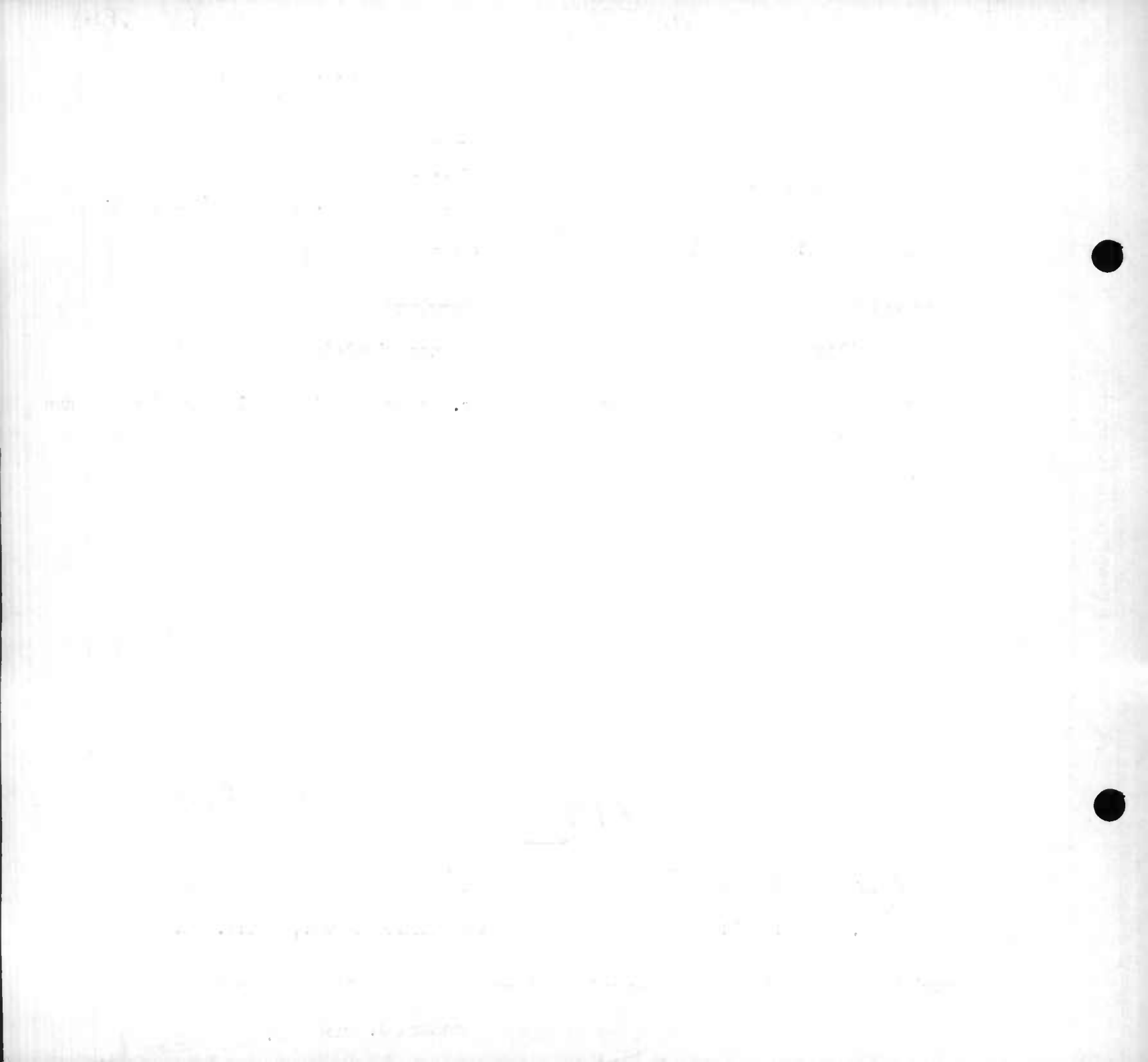
67 7690		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7690	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Casper Roy Hollen		August 10, 1967 3:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4600 Northwood Drive			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/14/1897	9. AGE (In years lost birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Retired
		10B. KIND OF BUSINESS OR INDUSTRY Railway Express	11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Howard Hollen			14. MOTHER'S MAIDEN NAME Cara Guyer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 162-12-7322		17. INFORMANT Mrs. Mabel A. Hollen	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Myocardial Infarction (B) Chronic Congestive Heart Failure (C)		CAUSE OF DEATH Sudden 4+ yrs.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1962 to August 10, 1967, that (we) last saw the deceased alive on August 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman Brecher				23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) Herman Brecher		23D. ADDRESS 443 E. 25th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/14/1967		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			
25B. NAME OF REGISTRAR Robert E. Fiske, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

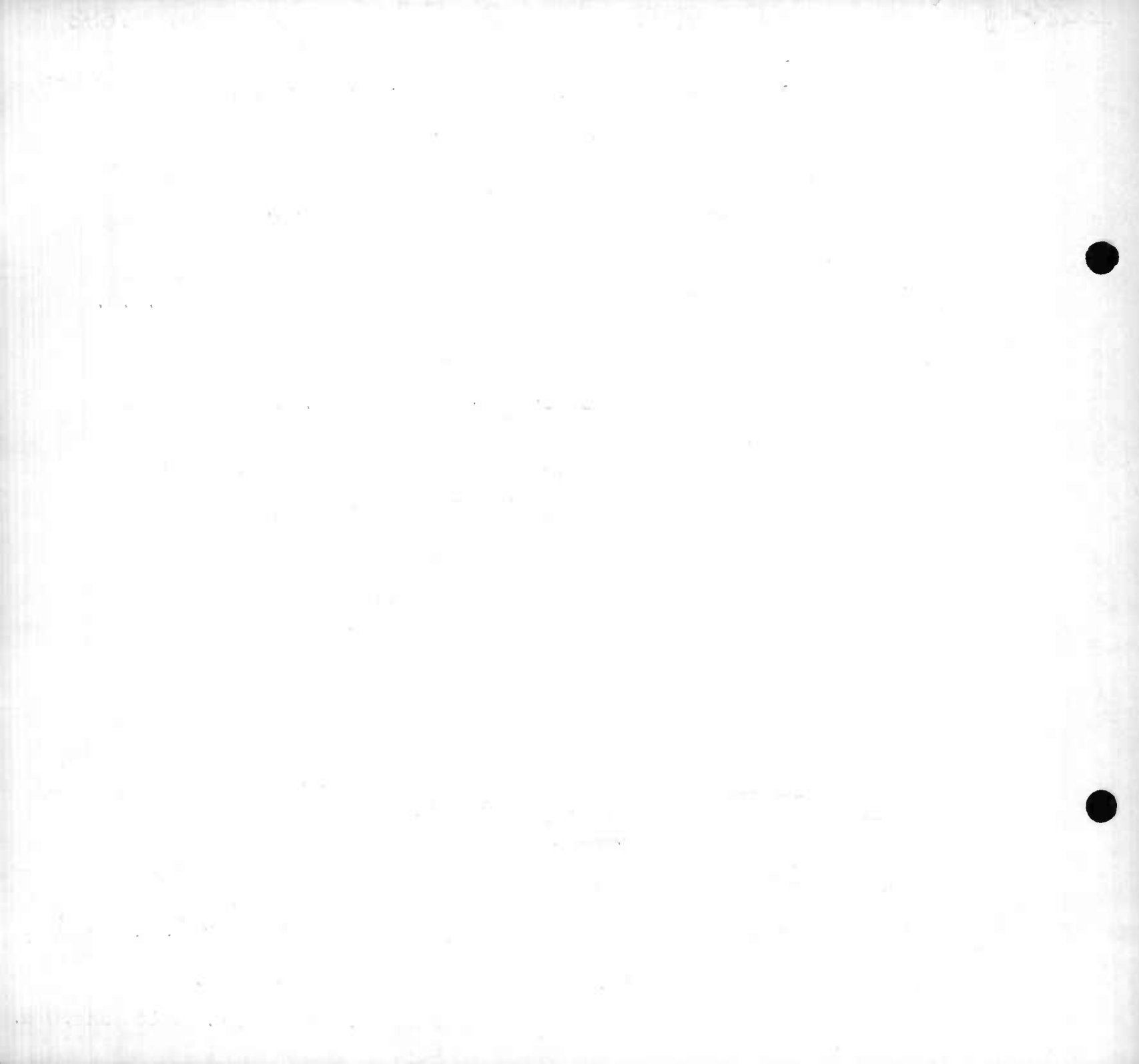
BIRTH NO. 67 7691				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7691	
<div style="display: flex; justify-content: space-between;"> <div> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) DORA WALTMAN</p> </div> <div> <p>2. DATE AND HOUR OF DEATH August 10 1967 8 30/9 M.</p> </div> </div>							
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Kenesaw Nursing Home</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-38 D. STREET ADDRESS (If rural, give location) 2601 Roslyn Ave. (Kenesaw Nursing Home)</p>			
<p>5. SEX Female</p>		<p>6. RACE White</p>		<p>7. MARRIED, NEVER MARRIED WIDOWED (specify)</p>		<p>8. DATE OF BIRTH 6/5/1886</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Henry Biltz</p>				<p>14. MOTHER'S MAIDEN NAME Anna Kienlein</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT ADDRESS Mr. DeForde Waltman 3012 Woodside Avenue</p>			
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) Cerebral hemorrhage (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) DUE TO</p> <p>INTERVAL BETWEEN ONSET AND DEATH 1 day</p>							
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>							
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 4/24 19 65 to 8/10 19 67, that (I) (we) last saw the deceased alive on 8/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE Robert A. Reiter</p>						<p>23B. DATE SIGNED 8/11/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) Dr. Robert Reiter</p>				<p>23D. ADDRESS M.D. 606 Edmondson Ave., Balto. Md.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 8/14/67</p>		<p>24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967</p>		<p>25B. NAME OF REGISTRAR Robert E. Fairbank</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd.</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

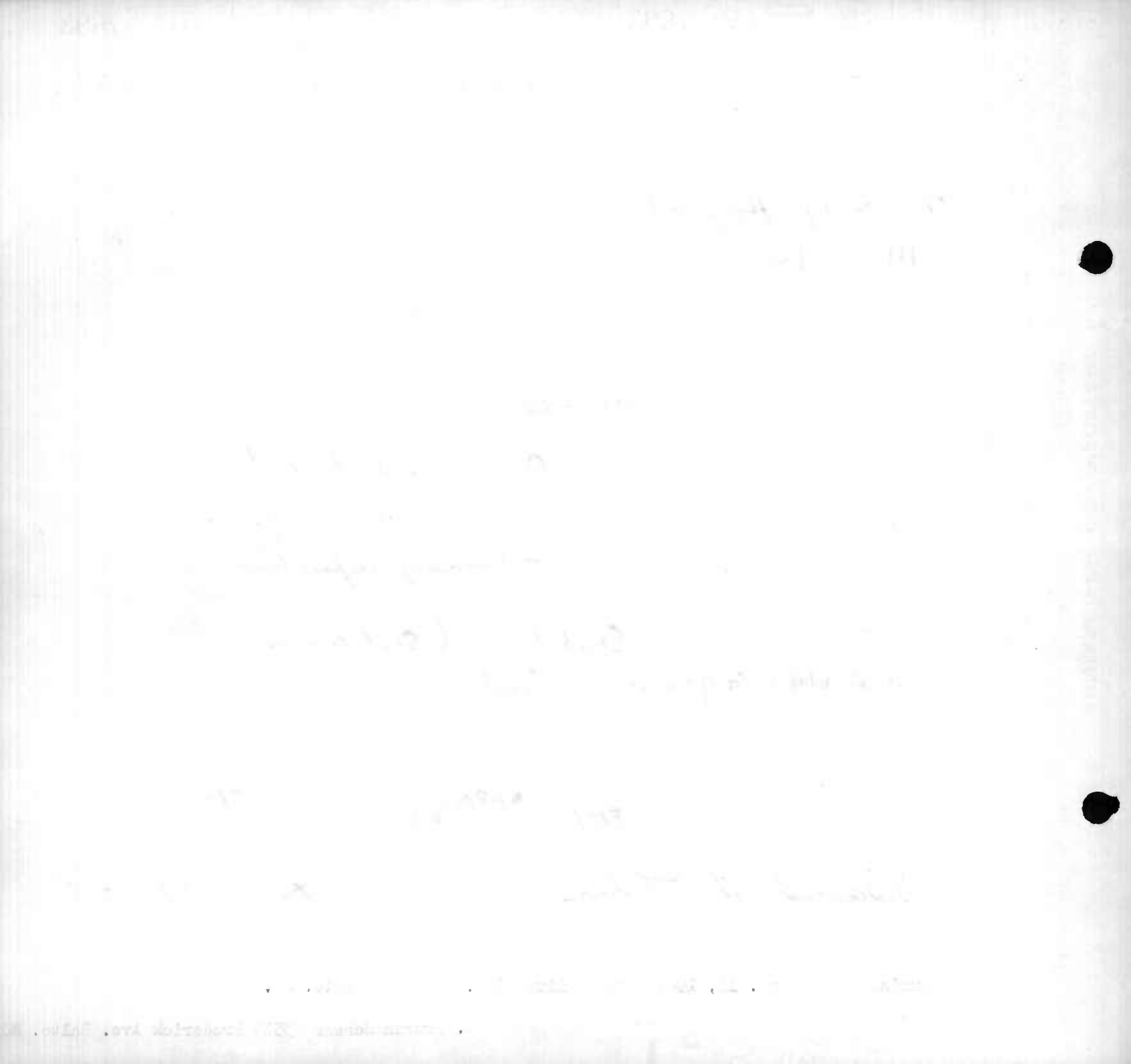
BIRTH NO. 67 7692		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7692	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Robert C Hall		August 10, 1967		7:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Gould Convalesarium 6116 Belair Road		Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21234 53-00 D. STREET ADDRESS (If rural, give location) 7803 1/2 Oak Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
male	white	widowed	5/19/1908	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Pressman		Sun Papers		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Frank Hall		Marie Wenke		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		213-03-2447		Miss Roberta L. Hall same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
163X I		Carcinoma of lung Metastasis to brain Secondary anemia		1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Severe hypotension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 11 1967 to Aug. 10 1967. that (I) lost saw the deceased alive on Aug 9 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
H. V. Harbold		Aug. 11, 1967			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
H. V. HARBOLD		4706 Harbold Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial				Parkwood Cemetery	
				24D. LOCATION (City, town, or county)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1967		Robert E. Jackson		Leonard J. Ruck, Inc. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

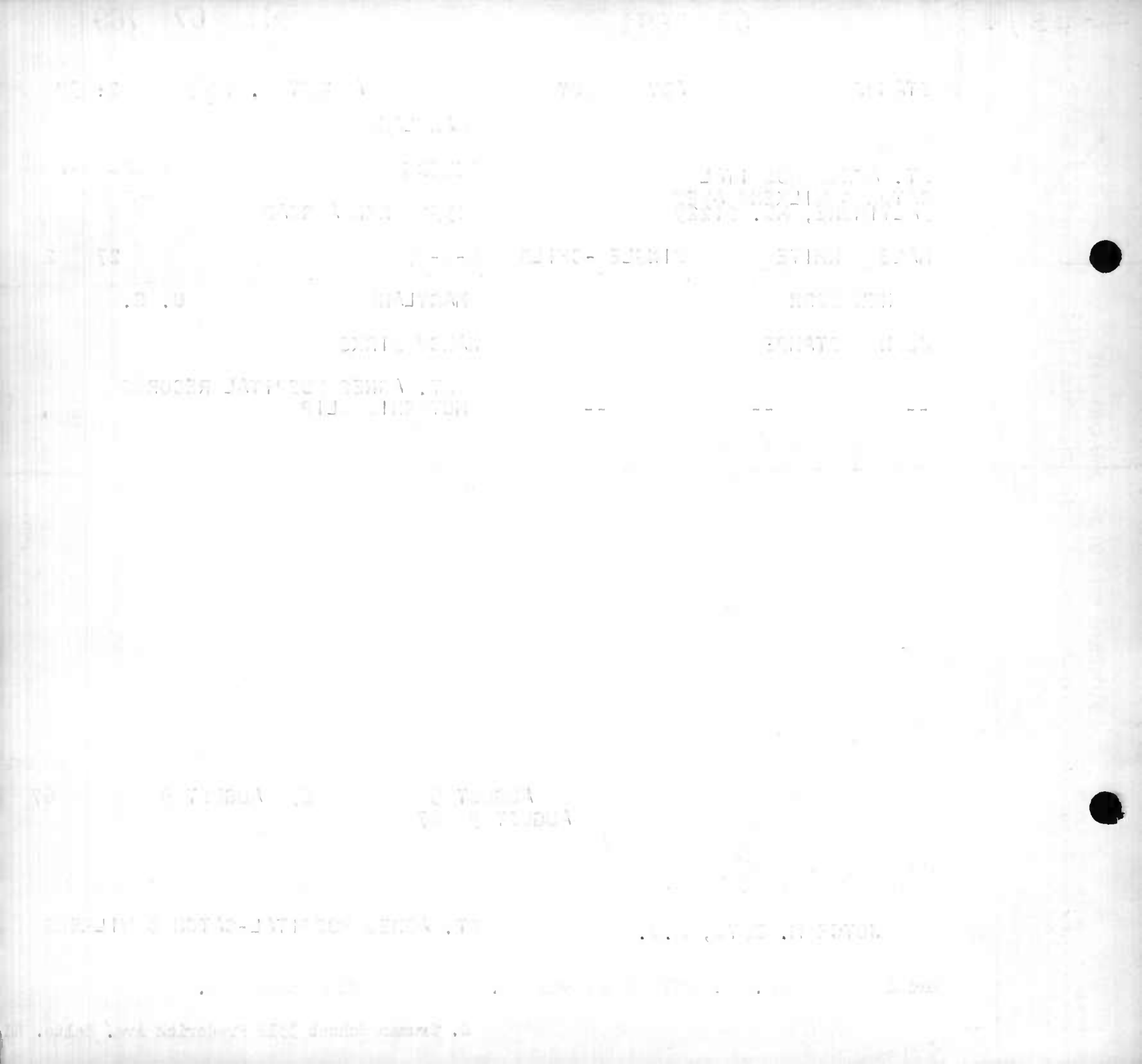
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7693	
<div style="display: flex; justify-content: space-between;"> 7-651 67 7693 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				(Type or Print) Turner, Earl R. (Turner)	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 916 W. Balto. St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) wid.	8. DATE OF BIRTH 9/7/94	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George W. Turner		14. MOTHER'S MAIDEN NAME Caroline Hafer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-3329A		17. INFORMANT daughter ADDRESS same	
18. 13311		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Carcinoma of the colon		INTERVAL BETWEEN ONSET AND DEATH 3 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Gastro-intestinal fistula			
		(C) Pulmonary infarction			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Staphylococcal septicemia			
19A. DATE OF OPERATION 5/24/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED transverse colon @ 61		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/18/67 19 to 8/8/67 19 67 , that (I) (we) last saw the deceased alive on 8/8/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David A. Parker M.D.				23B. DATE SIGNED 8/8/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 11, 1967		24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cem.	
24D. LOCATION Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR R. E. Farley, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab ADDRESS 3512 Frederick Ave., Balto., Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-16064 67. 7694				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7694	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
STAMPS				BABY		BOY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				AUGUST 9, 1967 2:05P M.			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVES BALTIMORE, MD. 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY G.A.C.			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERN			
5. SEX MALE				D. STREET ADDRESS (If rural, give location) 1352 BRENDA ROAD			
6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE -CHILD		8. DATE OF BIRTH 8-8-67		9. AGE (In years lost birthday) 27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JOHN STAMPS				14. MOTHER'S MAIDEN NAME NANCY DIRKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -- --		16. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS MOTHER'S SLIP			
18. 762.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral Pulmonary atelectasis				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO (B) DUE TO (C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 9 19 67 to AUGUST 9 19 67 , that (I) (we) last saw the deceased alive on AUGUST 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joyce M. Boyd				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-67	
23C. PHYSICIAN'S NAME (Type) JOYCE M. BOYD, M.D.				23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 11, 1967		24C. NAME of CEMETERY or CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glen Burnie Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave, Balto. Md	

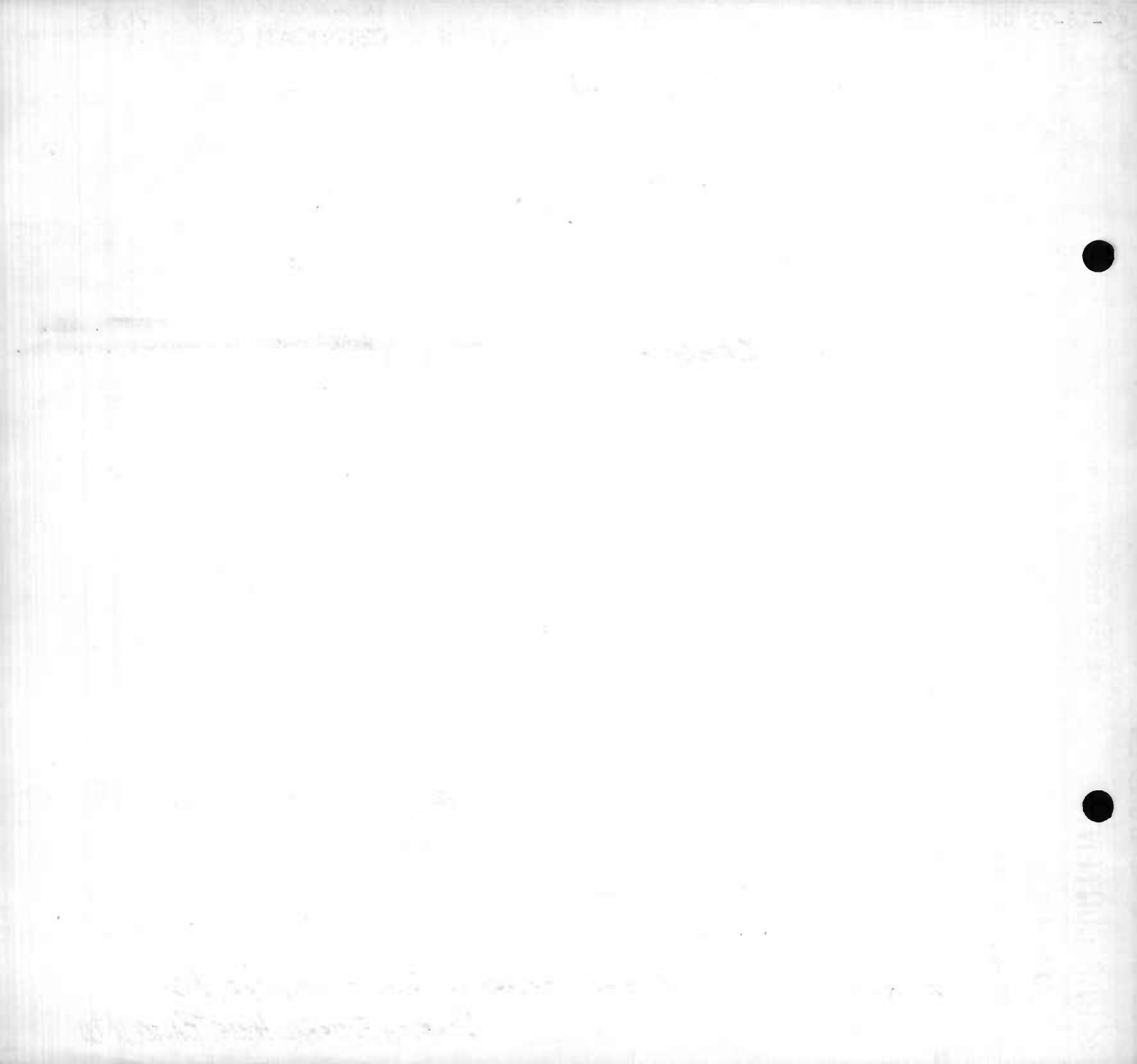


49-1967-73 GD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

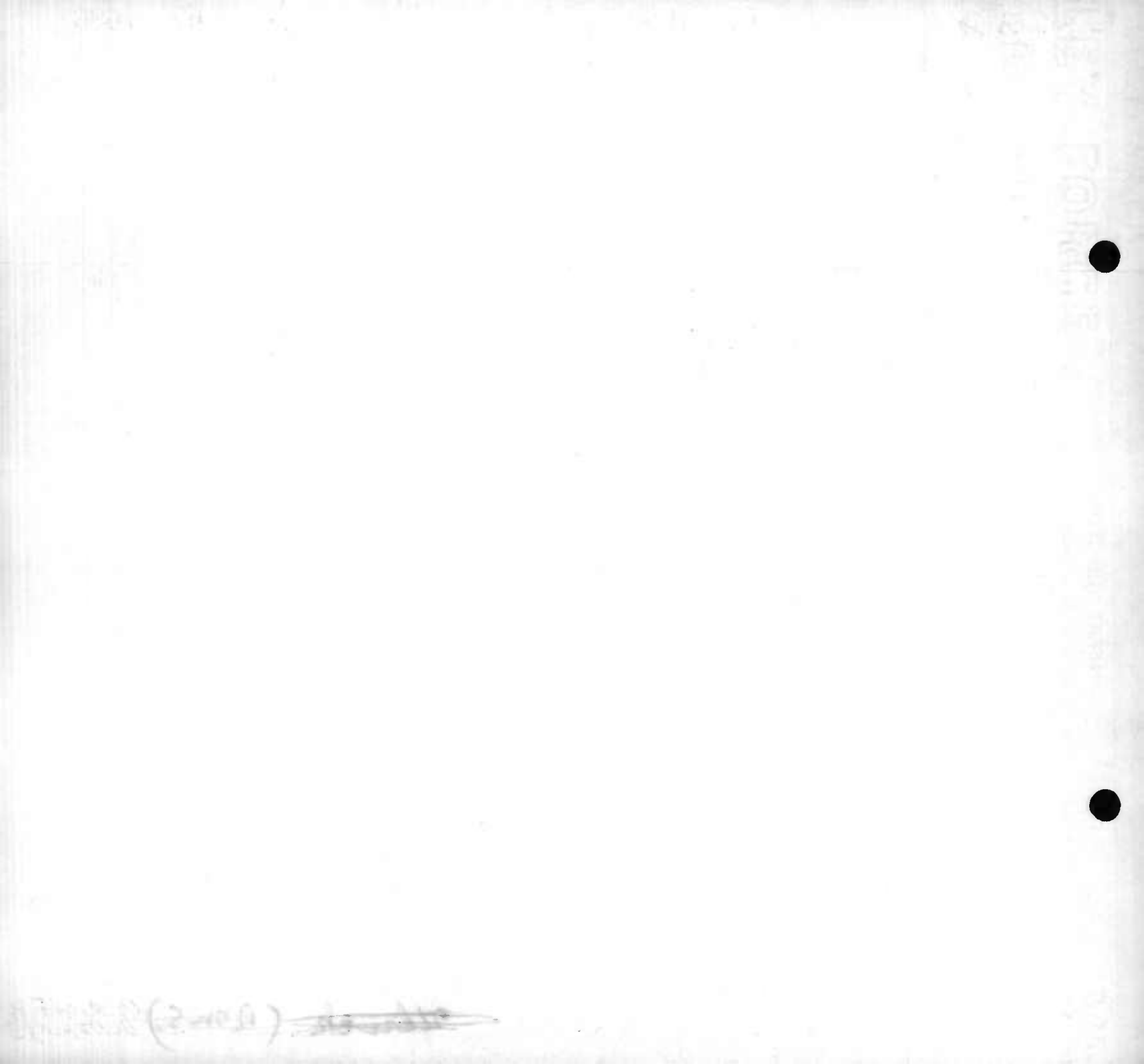
2-208		67 7695		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7695	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) LEAGUE, JOSEPH S				2. DATE AND HOUR OF DEATH 8/6/67 3PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
3 / BALTIMORE CITY HOSPITALS MD.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
4940 EASTERN AVENUE BALTO. 21224				D. STREET ADDRESS (If rural, give location) 610 N. LUZERNE AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER		8. DATE OF BIRTH 2-25-79	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CITY EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY CITY EMPLOYEE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT LEAGUE				14. MOTHER'S MAIDEN NAME MARY PERMELIA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 314-38-9264A		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS			
18. 422,114-177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ASCVD - chronic CHD				INTERVAL BETWEEN ONSET AND DEATH 7 years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chronic bronchitis & emphysema 5 yrs ca of prostate 3 yrs cerebral vascular disease 6 yrs							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/128 19 67 to 8/6 19 67 . that (I) (we) last saw the deceased alive on 8/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard Lippman				M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/6/67	
23C. PHYSICIAN'S NAME (Type) DR. LEONARD LIPPMAN				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. N			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY MOST HOLY REDEEMER CHURCH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR R. E. Finkbeiner		25C. FUNERAL DIRECTOR WICKICH FUNERAL HOME, BALTO, MD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

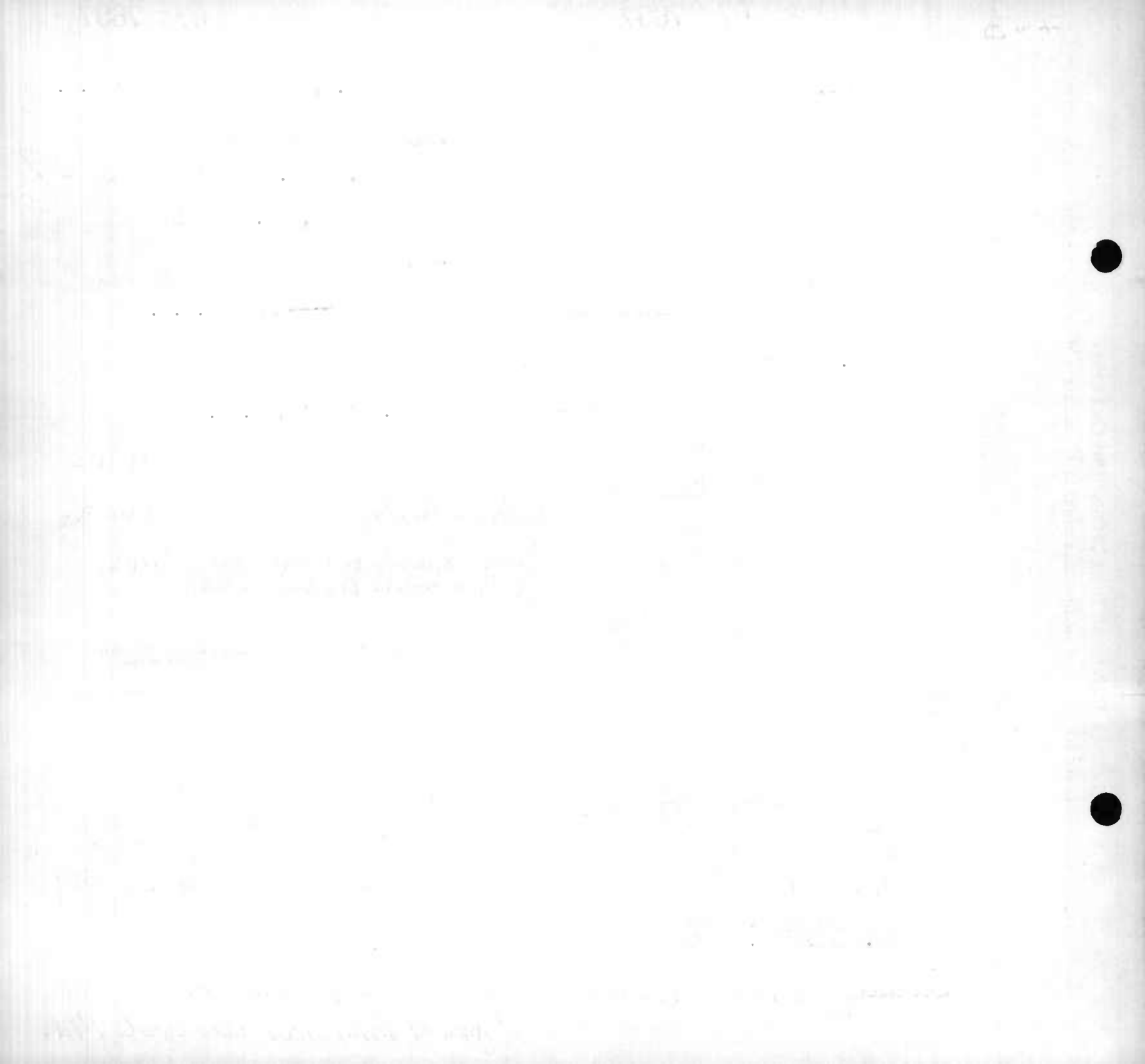
BIRTH NO. 67 7696				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7696	
1. NAME OF DECEASED (Type or Print) <u>Thomas Crowther</u>				2. DATE AND HOUR OF DEATH <u>8 Aug 1967</u> <u>5:30</u> <u>P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 Church Home & Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4 EASTSHIP RD</u>			
5. SEX <u>M</u>	6. RACE <u>CAUC</u>	7. <u>MARRIED</u> NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT 27-1885</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL INDUSTRY</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH CROWTHER</u> <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>ELLEN BURKE</u> <u>UNKNOWN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>160 03 9674</u>		17. INFORMANT <u>MRS GERTRUDE BUZZELL</u> <u>STREET IN LAW</u>		ADDRESS <u>4 EASTSHIP RD BALTO.</u>	
18. <u>42211</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>General Debilitation</u> <u>Malnutrition - Dehydration</u> <u>ASCVD</u>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 27</u> 19 <u>67</u> to <u>Aug. 8</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 8</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Francisco Baltazar</u> M.D.						23B. DATE SIGNED <u>8/8/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANCISCO BALTAZAR M.D.</u>				23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/10/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>MEADOW RIDGE</u>		24D. LOCATION (City, town, or county) (State) <u>ELK RIDGE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairburn</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>CHURCH F.H. DUNDALK, MD</u>	



FUNERAL DIRECTOR: IMPORTANT

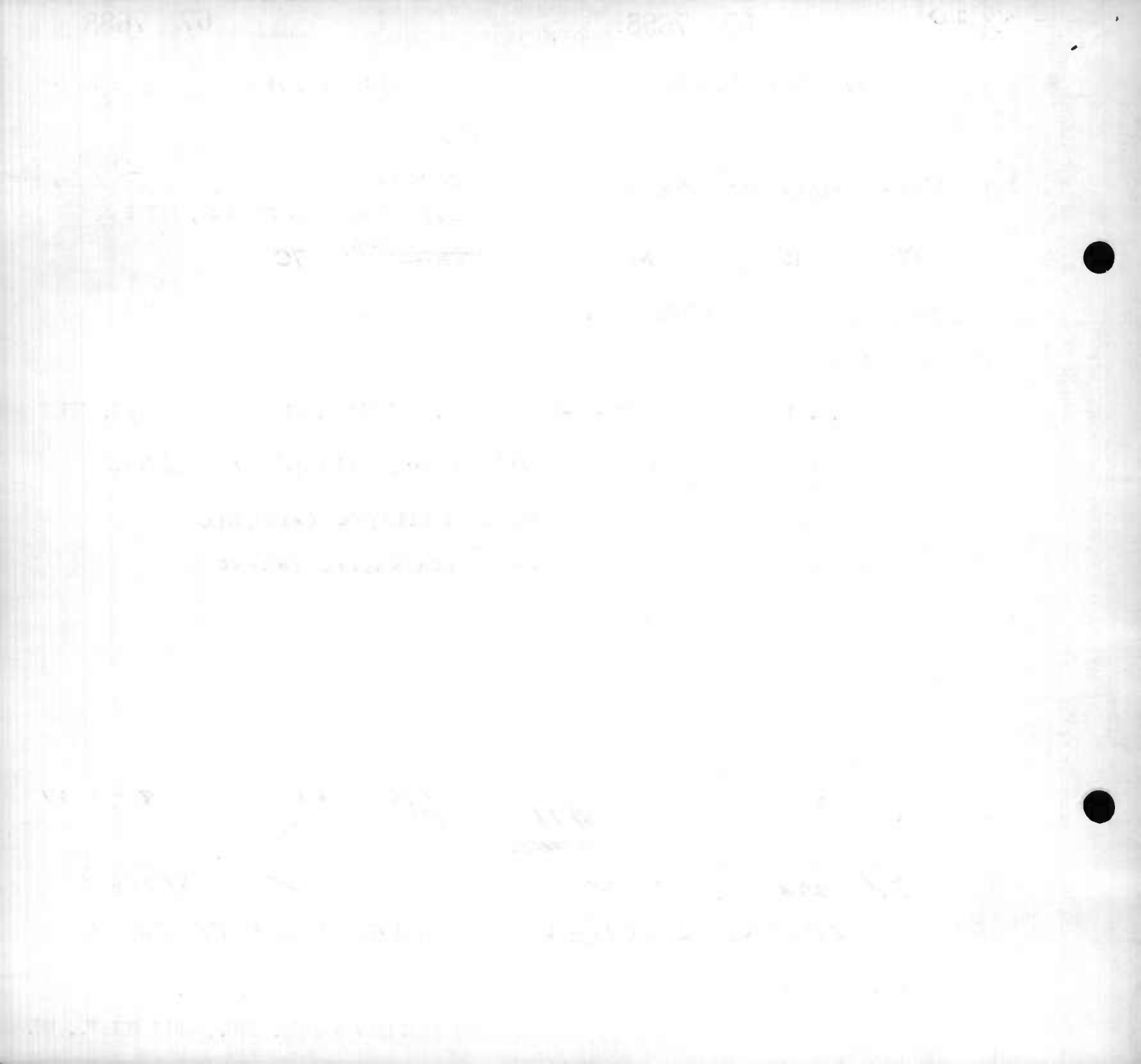
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7697	
BIRTH NO. 67 7697				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mrs. Agnes McCarter			2. DATE AND HOUR OF DEATH Aug. 6, 1967 11 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 91 KESWICK			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO		
5. SEX F 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow			8. DATE OF BIRTH Feb. 15, 1881 9. AGE (In years lost birthday) 86		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse			11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.		
10B. KIND OF BUSINESS OR INDUSTRY NURSE			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James N. Wells			14. MOTHER'S MAIDEN NAME Susan Crandell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-14-4995		
17. INFORMANT Mary B. DiPaula, R. N.			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic vascular disease			INTERVAL BETWEEN ONSET AND DEATH 4 yrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Osteoarthritis			3 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cancer Breast post operative with metastatic skin lesions, controlled			5 yrs		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 15 Jan 1963 to 6 Aug 1967 , that (I) (we) lost saw the deceased alive on 6 Aug 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aubrey D. Richardson			23B. DATE SIGNED 7 Aug 1967		
23C. PHYSICIAN'S NAME (Type or Print) Aubrey D. Richardson			23D. ADDRESS 700 W. 40th Street		
24A. BURIAL CREMATION REMOVAL (Specify) Burial			24B. DATE 8-9-67		
24C. NAME OF CEMETERY or CREMATORY Cedar Bluff			24D. LOCATION (City, town or county) (State) Annapolis, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			25B. NAME OF REGISTRAR Robert E. Fisher		
25C. FUNERAL DIRECTOR John M. Taylor			ADDRESS Annapolis, Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7698		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7698	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HYMAN GLASS		2. DATE AND HOUR OF DEATH AUG. 7, 1967		6:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.		D. STREET ADDRESS (If rural, give location) 3100 BANCROFT RD., APT E	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTO.		(If not in hospital or institution, give street address or location)		5. SEX M		6. RACE W	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 2/28/17		9. AGE (In years lost birthday) 70		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10B. KIND OF BUSINESS OR INDUSTRY MATRESS MFG.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB GLASS		14. MOTHER'S MAIDEN NAME ANNA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. 1 ARMY		16. SOCIAL SECURITY NO. 578-46-7320	
17. INFORMANT MRS. RAY GLASS, 3100 BANCROFT ROAD, APT E		ADDRESS		18. CAUSE OF DEATH MYOCARDIAL INFARCTION 2 WKS		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES		20. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DIS.		(B) ARTERIOSCLEROTIC CARDIOVASC.	
(C) LEFT VENTRICULAR FAILURE		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 2/25 1967 to 8/7 1967 , that (we) last saw the deceased alive on 8/7 1967 and that (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.		23A. SIGNATURE Edward R. Cohen M.D.		23B. DATE SIGNED 8/7/67		23C. PHYSICIAN'S NAME (Type) EDWARD R. COHEN M.D.	
23D. ADDRESS SINAI HOSP. OF BALTO		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/67		24C. NAME of CEMETERY or CREMATORY LUBOWITZ NUST ART	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Edw. E. Fajana		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7699	
00 BIRTH NO.		67 7699		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
AMELIA B. MANN		AUGUST 7, 1967		5 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
00 ESPLANADE APARTMENTS, APT 9 H		MARYLAND			
5. SEX FEMALE		6. RACE WHITE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH FEB. 7, 1880		9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		ALBANY, NEW YORK	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
DANIEL BACHRACH		AMELIA GOLDSMITH		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		UNKNOWN		HELENE MRS. HELENE L. MOSES, 6701 PARK HEIGHTS AVE. APT 4 E	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
720.1 I		(A) DUE TO Coronary thrombosis		Instantaneous	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Atherosclerosis		10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1964 to August 7, 1967, that (I) (we) last saw the deceased alive on Sept 17, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Alan Bernstein		23B. DATE SIGNED 8/7/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
Dr. Alan Bernstein		819 Park Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/9/67		Baltimore Hebrew	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1967		Robert E. Farley, M.D.		Sol Levinson & Bros. Inc., 6010 Reist., Rd.	
24D. LOCATION (City, town, or county) (State)		Baltimore, Maryland			

100/100

FUNERAL DIRECTOR: IMPORTANT

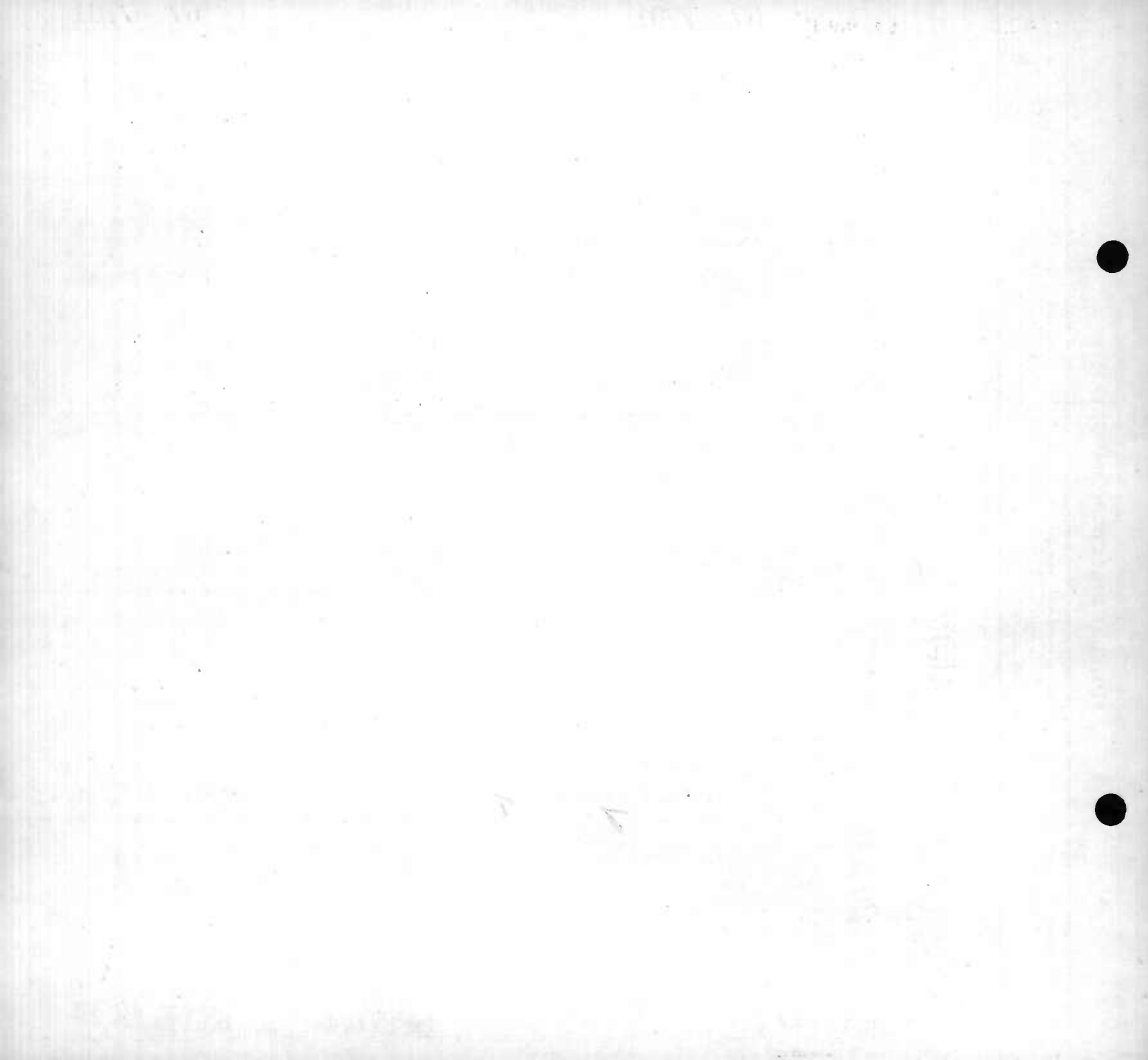
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7700		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7700	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HENDRICK VAN REET		2. DATE AND HOUR OF DEATH Aug 5, 1967 8:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home + Hospital		A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Z-03			
		D. STREET ADDRESS (If rural, give location) 1624 THAMES ST			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 4-10-1900	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENDRICK VAN REET			14. MOTHER'S MAIDEN NAME Ana Nelson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X410021		CAUSE OF DEATH (A) Intracerebral Hemorrhage DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Old Pulmonary Tuberculosis, ? prob. reactivation			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-5 19 67 to 8-5 19 67 , that (I) (we) last saw the deceased alive on 8-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/8/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR, JR.		23D. ADDRESS CHURCH HOME & HOSP. ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 8-10-67	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
				UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Farley, Jr.		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

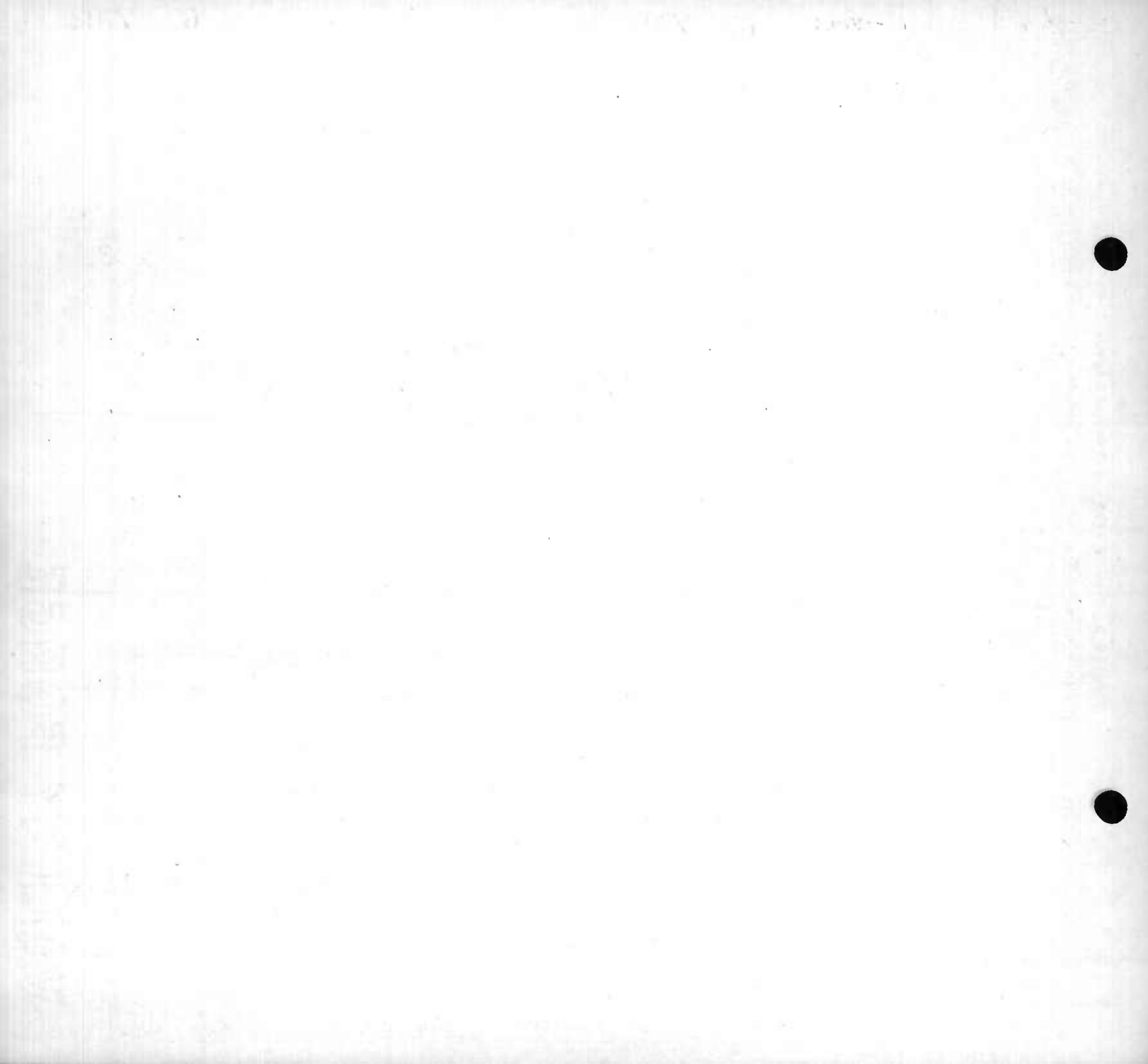
BIRTH NO. 67-13833 67 7701		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7701	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Baby Aine Broden (BRODEN)</i>			2. DATE AND HOUR OF DEATH <i>7-17-67 1:12 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 19-01</i>		
<i>38</i>			D. STREET ADDRESS (If rural, give location) <i>529 NORTH STRICKEN ST.</i>		
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>7-17-67</i>	9. AGE (In years last birthday) <i>newborn</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>newborn</i>			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Johnny Broden</i>		
14. MOTHER'S MAIDEN NAME <i>Bessie Harvin</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		
16. SOCIAL SECURITY NO. <i>N/A</i>			17. INFORMANT <i>GARY A. FLEHING</i>		
ADDRESS <i>Univ. Md. Hosp.</i>			18. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <i>IMMATURITY</i> DUE TO (B) <i>RESPIRATORY DISTRESS</i> DUE TO (C) —		
INTERVAL BETWEEN ONSET AND DEATH <i>20hr/shin.</i> <i>20hr/shin.</i>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>7-17-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from <i>7-16-67</i> to <i>7-17-67</i> , that (I) (we) lost saw the deceased alive on <i>7-17-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gary A. Flehing</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7-17-67</i>
23C. PHYSICIAN'S NAME (Type) <i>GARY A. FLEHING</i>			23D. ADDRESS <i>University of Maryland Hosp. ANATOMY BOARD OF MARYLAND</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>8-4-67</i>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county) (State) <i>MORTUARY SERVICE - BEND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 14 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BEND</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

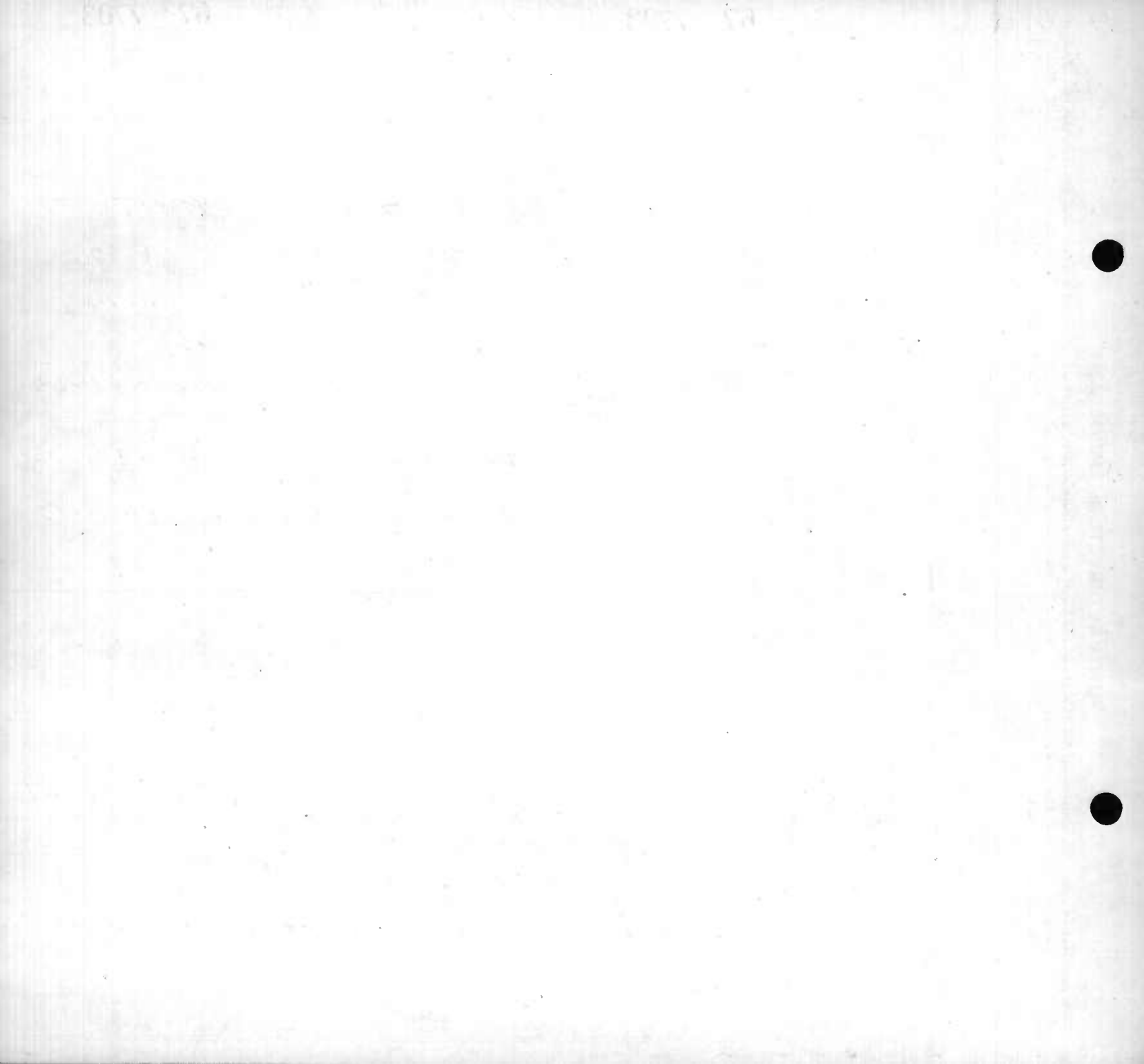
BIRTH NO. 67-14132 67 7702				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7702	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Eugene Boy CLARK (CLARK)		7-22-67 4:30 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
38 UNIVERSITY of MARYLAND HOSPITAL				Maryland: BALTIMORE			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE 17-03			
D. STREET ADDRESS (If rural, give location)				801 HARLEM AVE.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	NEGRO	WIDOWED, DIVORCED (specify)	7-22-67				3 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Newborn				Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CARINGTON RUFUS CLARK				DARLENE WILLIAMSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						GARY A. FLEMING Univ. Md. Hosp.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMATURITY 3 hours			
				(B) RESPIRATORY DISTRESS 3 hours			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-22-67 to 7-22-67, that (I) (we) last saw the deceased alive on 7-22-67 and that (n)(my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
GARY A. FLEMING						7-22-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
GARY A. FLEMING				UNIVERSITY of Maryland ANATOMY BOARD of BALTIMORE			
24A. BURIAL CREATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
		8-4-67		JOHNS HOPKINS MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1967		Robert E. Finkbeiner		MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

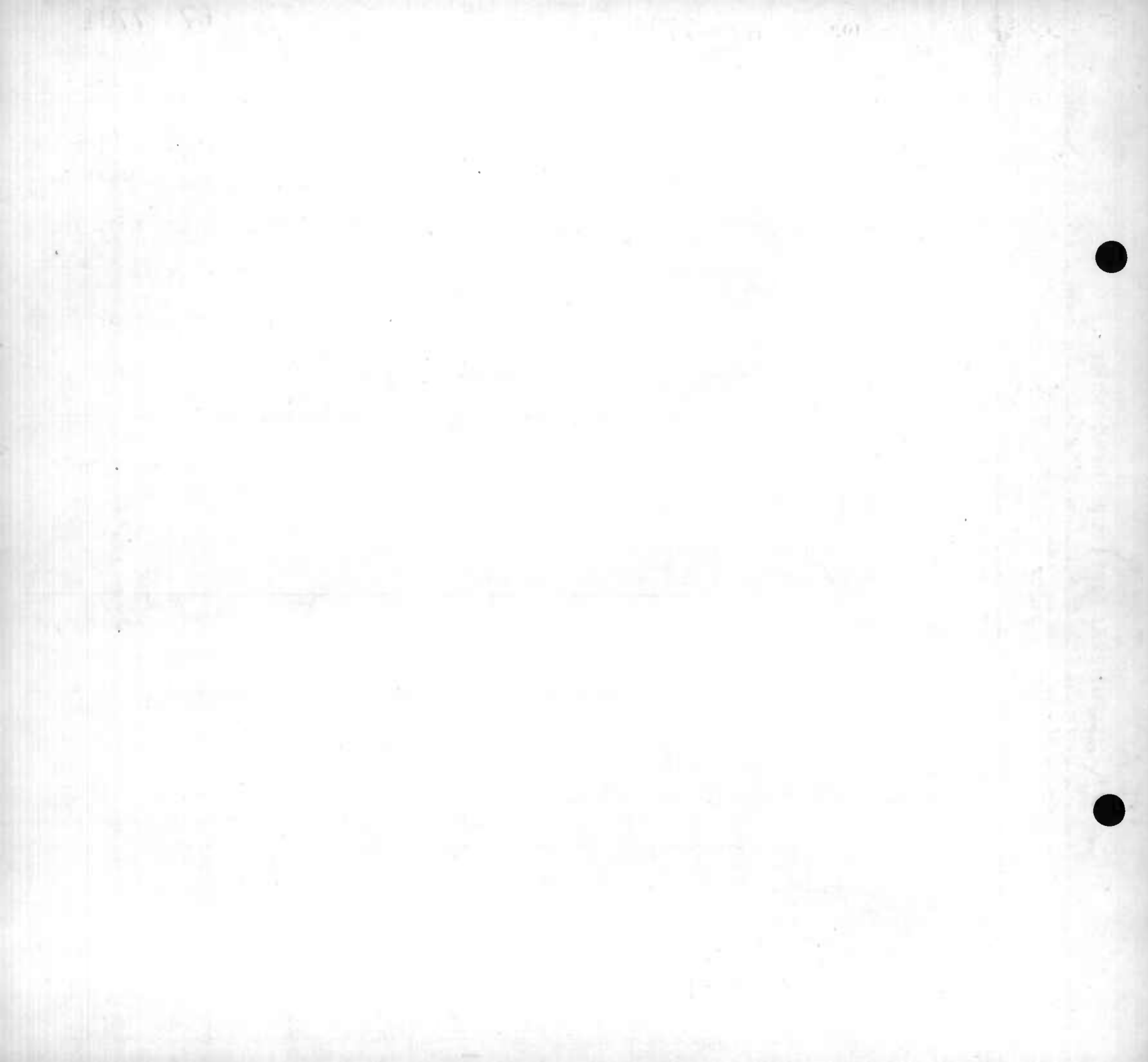
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67-13831 67 7703					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 7703				
1. NAME OF DECEASED (Type or Print) <u>Baby Girl HEARN</u>					2. DATE AND HOUR OF DEATH <u>7-17-67 5:50 PM</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University - Maryland</u>					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1435 W. GREENMOUNT RD.</u>				
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>7-15-67</u>	9. AGE (In years last birthday) <u>NEARLY</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>MINOR HEARN</u>					14. MOTHER'S MAIDEN NAME <u>CALLISTUS NEAL</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>GARY A. FLEMING</u>			ADDRESS <u>UNIV. Md. Hosp.</u>	
18. <u>773.51</u> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>IMMATURITY</u>					<u>44 hours</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>RESPIRATORY DISTRESS</u>					<u>44 hours</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> 19 <u>67</u> to <u>7-17</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7-17</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We) (did) (did not)</u> view the body after death.									
23A. SIGNATURE <u>Gary A. Fleming</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7-17-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY A. FLEMING</u>					23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSP.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <u>8-4-67</u>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>				



FUNERAL DIRECTOR: IMPORTANT

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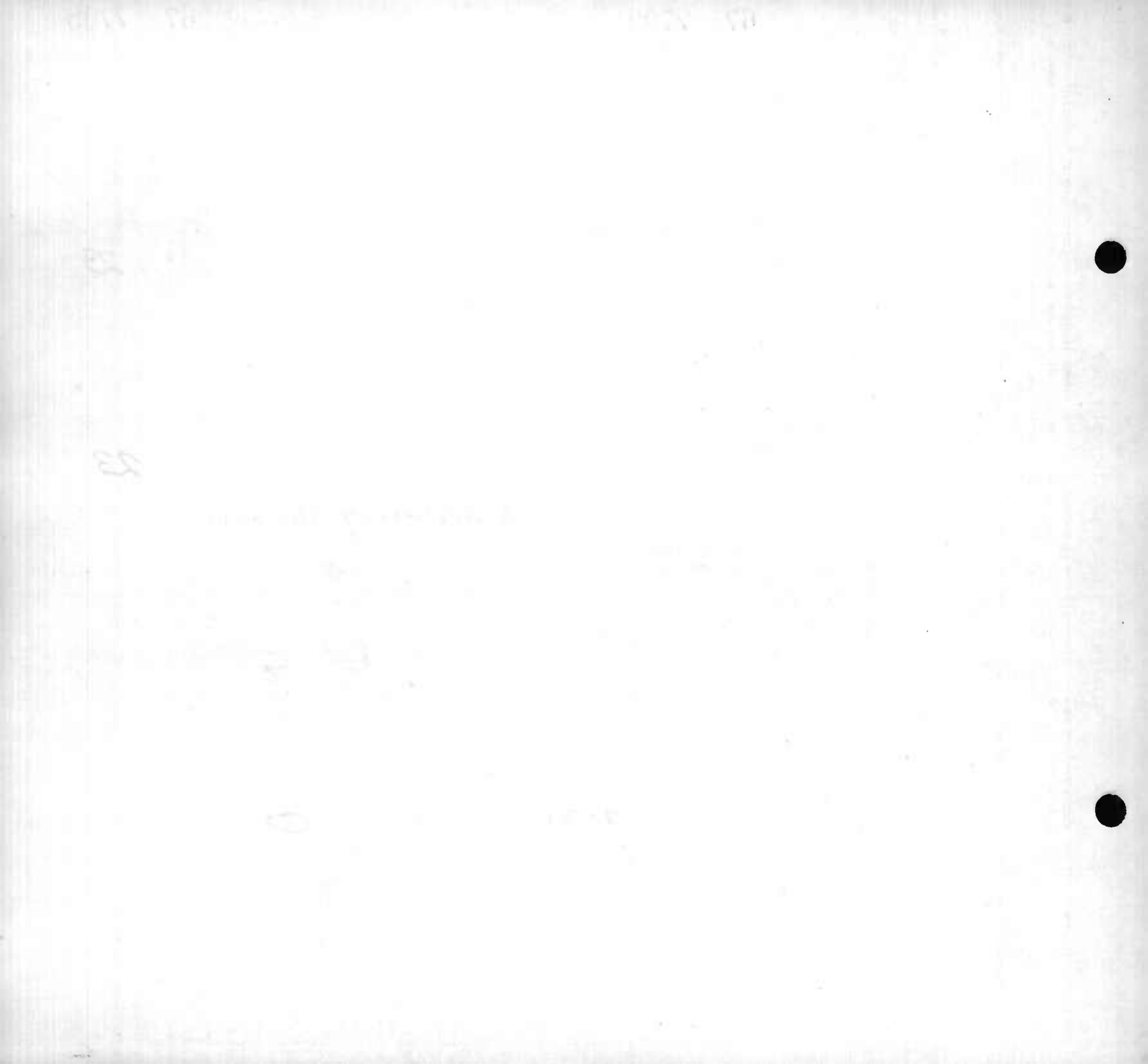
BIRTH NO. <u>67-14103</u>		67 7704		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>67 7704</u> ✓	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>BABY GAIL STANLEY</u>				2. DATE AND HOUR OF DEATH <u>7/19/67 - F.</u> <u>5:30 A.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>UNIV. Hosp Bldg MD. A.C.</u> B. COUNTY <u>Allen Burnie Md. 52-00</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <u>218 King George Drive</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>7/19/67</u>	9. AGE (In years, last birthday) <u>1</u> <u>45</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A - MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles</u>				14. MOTHER'S MAIDEN NAME <u>Betty</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ELLIS T. TUNN M.D</u>		ADDRESS	
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>IMMUNITY</u> DUE TO (B) <u> </u> DUE TO (C) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr. 45 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>No</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4 AM 7/19/67</u> to <u>5:30 AM 7/19/67</u> , that (I) (we) last saw the deceased alive on <u>7/19/67 5:30 AM</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Elliot S. Tokar</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/19/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELLIS T. TOKAR</u>				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> <u>ANATOMY BOARD OF MARYLAND</u>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>8-4-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE - BCHD</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

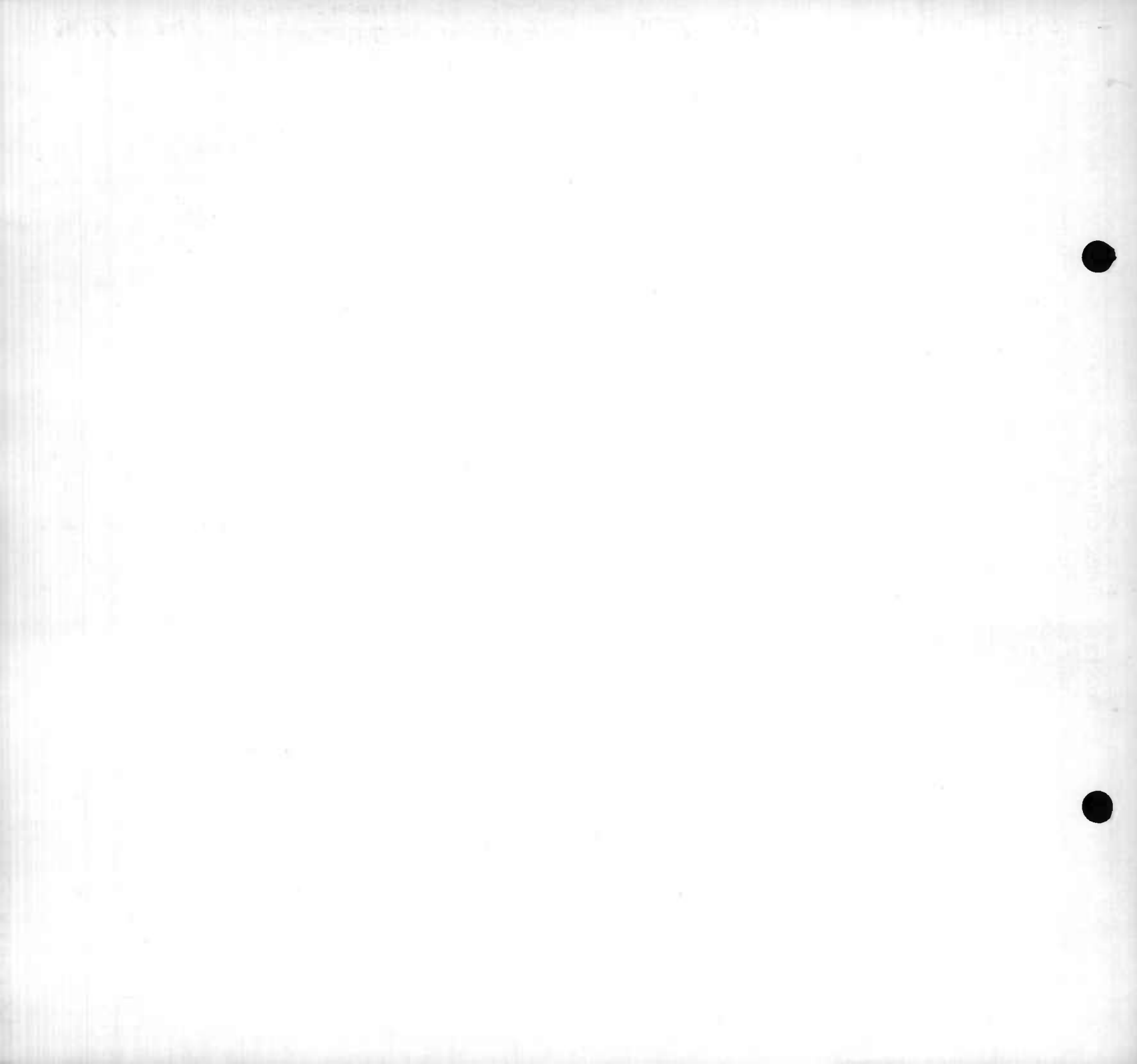
BIRTH NO. <u>67-14881</u>		67 7705		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 7705</u>	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Major</u>				2. DATE AND HOUR OF DEATH <u>7.31.67</u> <u>11.30 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hosp.</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Univ. Hosp.</u>		B. COUNTY <u>X</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balt.</u>		<u>25-33</u>	
				D. STREET ADDRESS (If rural, give location) <u>2444 Wilgray Ct. Balt. Md.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>7.30.67</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliner Paron</u>				14. MOTHER'S MAIDEN NAME <u>Oletria Major</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <u>775.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory Distress</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>23 hrs.</u> <u>23 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>U</u> (this hospital) attended the deceased from <u>7.30.67</u> 19 <u>67</u> to <u>7.31.67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-31</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M Khan</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7.31.67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Misbah Khan</u>				23D. ADDRESS <u>Univ. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-4-67</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMIC</u>		24D. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		ADDRESS <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

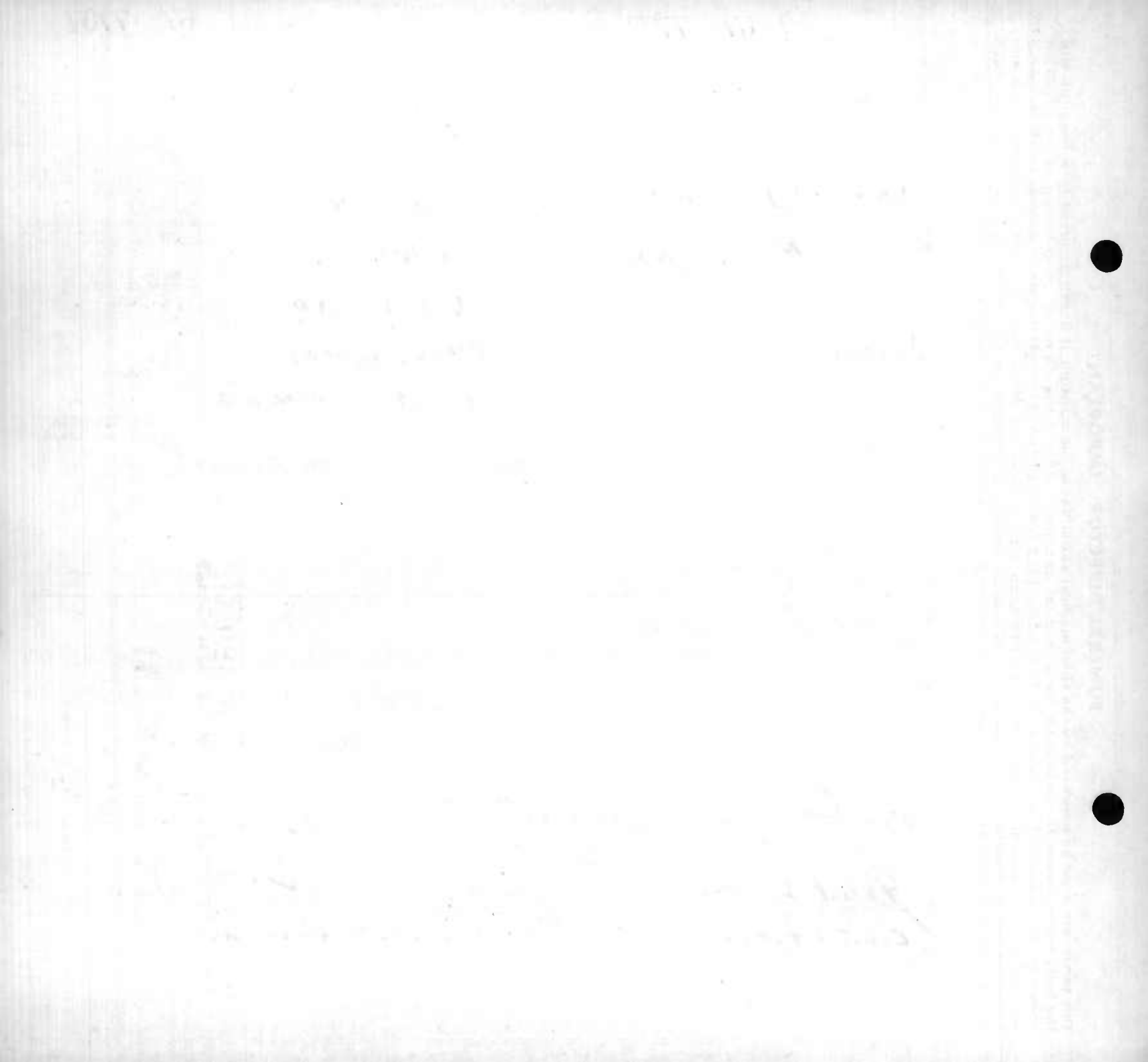
BIRTH NO. <u>67-14371</u> <u>67</u> <u>7706</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>7706</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EDWARDS, LEONARD TROY</u>		2. DATE AND HOUR OF DEATH <u>JULY 28 1967</u> <u>6:30</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY OF MARYLAND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>15</u> <u>28-41</u> D. STREET ADDRESS (If rural, give location) <u>4009 ELDERON AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>7-18-67</u>	9. AGE (In years lost birthday) <u>0</u> <u>10</u> <u>0</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>LAMONT EDWARDS</u>			14. MOTHER'S MAIDEN NAME <u>LILLIAN SMITH</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>HOSPITAL CHART</u>		
18. <u>759.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>① PNEUMONIA</u> DUE TO (B) <u>MULTIPLE CONGENITAL ANOMALIES</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>WHOLE LIFE</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>JULY 28</u> 19 <u>67</u> to <u>JULY 28</u> 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>JULY 28</u> 19 <u>67</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.					
23A. SIGNATURE <u>Theodore Wolff</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-28-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>THEODORE WOLFF</u>		23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>8-4-67</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

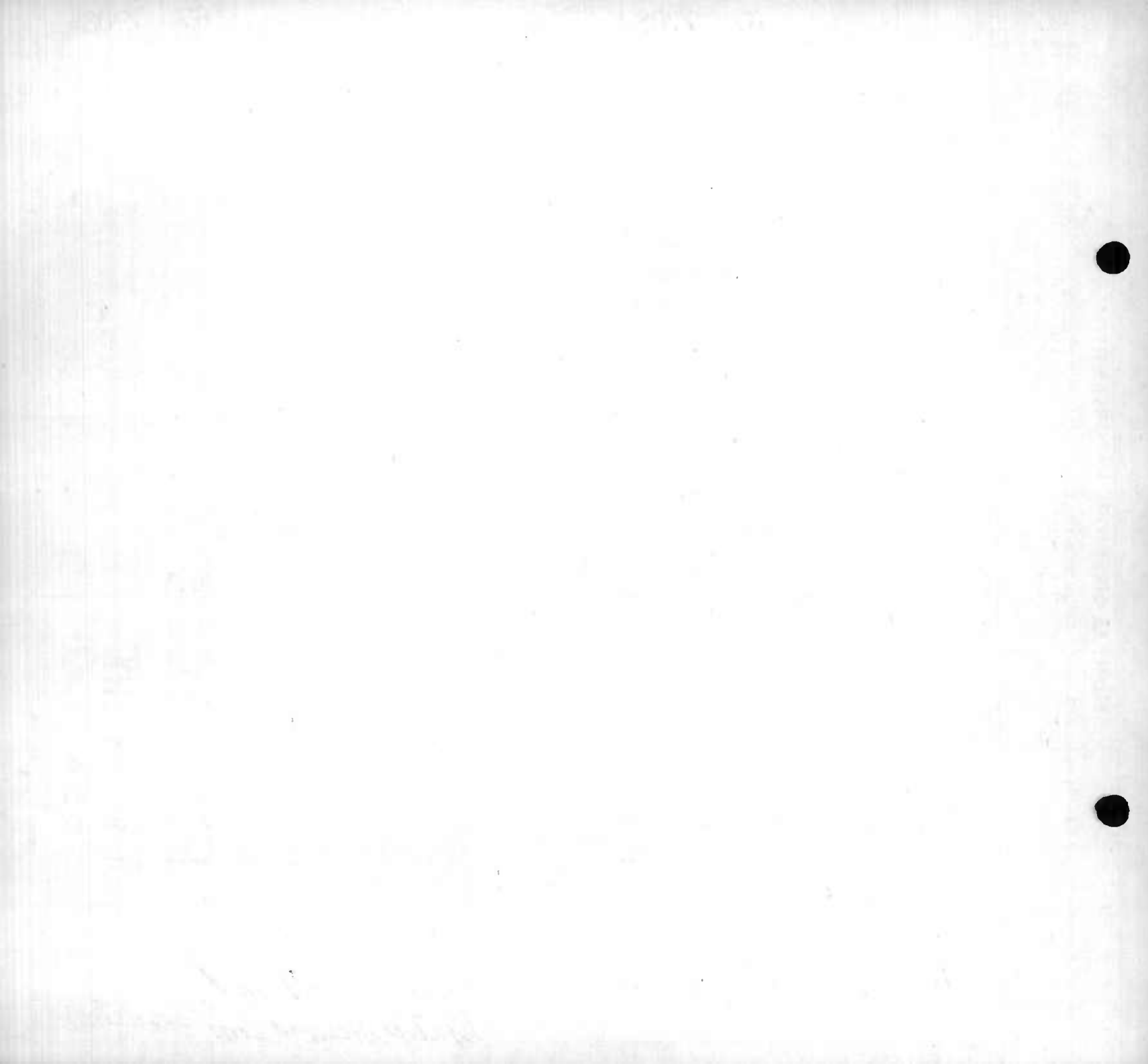
BIRTH NO. 67-14114 67 7707				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7707	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY Grl HUBBARD (HUBBARD)				7/25/67 5:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY Hospital				A. STATE MD B. COUNTY BALTO.			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				UN. H. 1827 Eagle St.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NM	8. DATE OF BIRTH 7/23/67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
			U.S.A. - MD		USA		
13. FATHER'S NAME Joseph			14. MOTHER'S MAIDEN NAME MARY SANDERS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					ELLIS S. TOKAR M.D. UN. H. Bldg		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) Respiratory Distress Syndrome		4 Hrs. 30 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/23/67 19 to 7/25/67 19, that (I) (we) last saw the deceased alive on 7/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ellis S. Tokar				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/25/67	
23C. PHYSICIAN'S NAME (Type) ELLIS S. TOKAR				23D. ADDRESS JOHNS HOPKINS MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-4-67		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE		ADDRESS BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

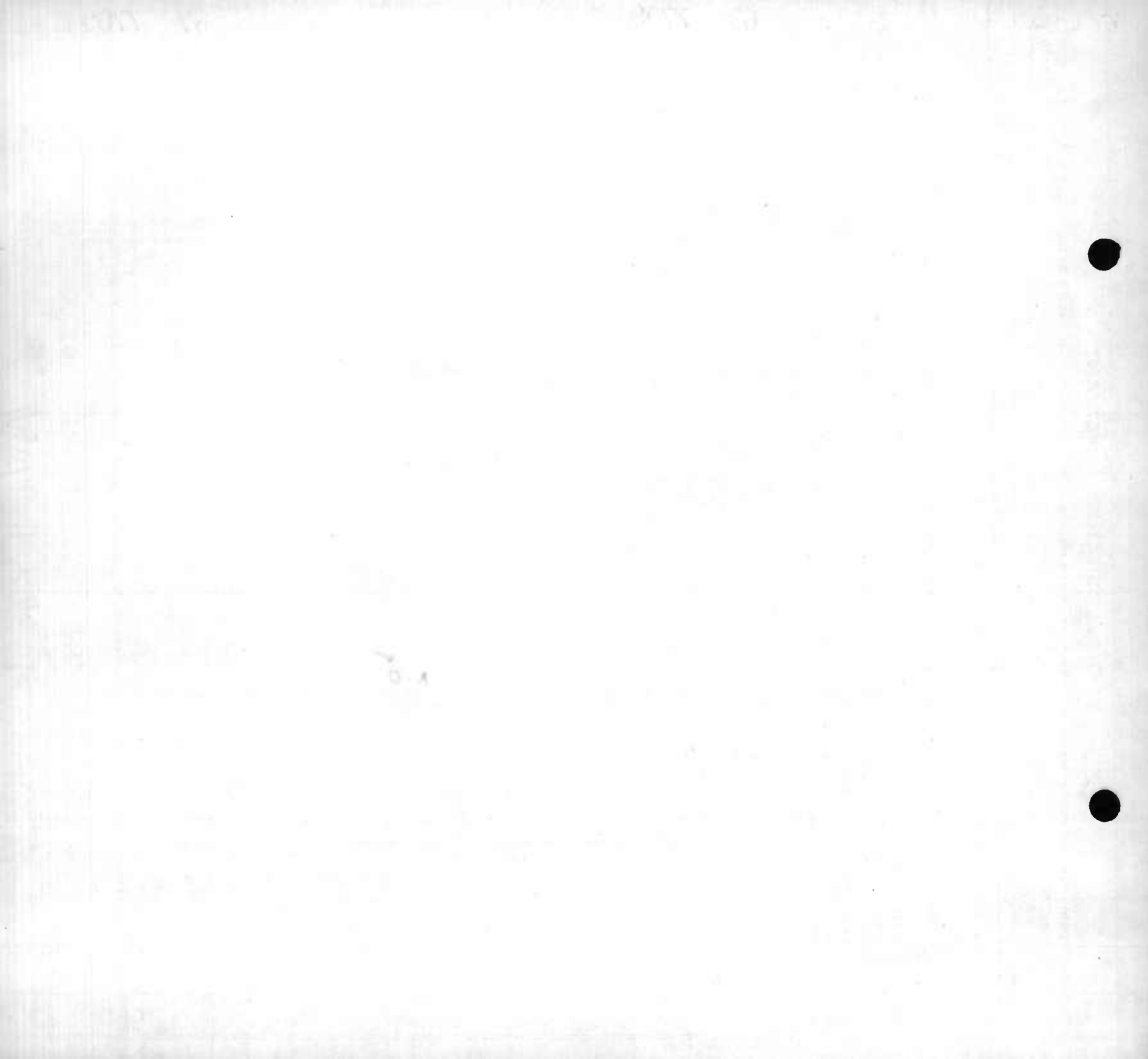
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7708	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARY ANN Bresnik		8-10-67		5:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
90 Little Sisters of The Poor		MD.			
1200 VALLEY ST.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
BALT. MD. 21202		D. STREET ADDRESS (If rural, give location)		10-01	
1200 VALLEY ST.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED, DIVORCED (specify)	Sept. 13, 1879	88	AUSTRIA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				AUSTRIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Simon Majcen		?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-4-68640		Little Sis of the Poor	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 1966 to Aug 40 1967, that (I) (we) last saw the deceased alive on Aug. 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Stanley Ankudas		8.11.67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
STANLEY Ankudas		1101 MAIDEN CHOICE LANE			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Aug 12/67	Sacred Heart Sem	BALT MD		
25A. DATE RECEIVED BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1967	Robert E. Farkner, M.D.	Philip Henry Jones		2024 Williams St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-15429</u> <u>67</u> <u>7709</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>7709</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Girl Mumford</u>		2. DATE AND HOUR OF DEATH <u>Aug 2, 1967</u> <u>2¹⁵ P.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>13-03</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u> <u>21217</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 md. GEN. Hosp</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>2300 Eutaw St</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NB</u>	8. DATE OF BIRTH <u>Aug 2, 1967</u>	9. AGE (In years lost birthday) <u>-</u> <u>-</u> <u>5</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Virgil Mumford</u>		14. MOTHER'S MAIDEN NAME <u>Pearlie Mae McKnight</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother</u>	
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <u>Yes</u> or No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>8</u> <u>2</u> <u>67</u> <u>2:15 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> <u>1967</u> to <u>Aug 2</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 2</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Vilma F. Tadalan</u> M.D.		23B. DATE SIGNED <u>8-2-67</u>		23C. PHYSICIAN'S NAME (Type) <u>VILMA F. TADALAN</u> M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-3-67</u>	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		25D. ADDRESS	



H-1257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 7710

BIRTH NO. 67-89412 67 7710

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Richard J. Hopkins

2. DATE AND HOUR OF DEATH

8-3-67

6:30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

BALTIMORE

C

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

6738 F TOWNBROOK DRIVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED

8. DATE OF BIRTH

4-28-67

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3 6

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 75-4-71

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cardiac & respiratory arrest

DUE TO

20 min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Inadequate pulmonary reserve

DUE TO

3 days

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Truncus arteriosus

since birth

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

3 7/28/67

Truncus arteriosus

YES

NO

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 7/21 19 67 to 8/3 19 67,
that (X) (we) last saw the deceased alive on 8/3 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/3/67

23C. PHYSICIAN'S
NAME (Type)

DENIS H. TYRAS

M.D.

23D. ADDRESS

ANATOMY DEPT OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

8-7-67

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 14 1967 P. O. & E. F. D. M. A.

MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

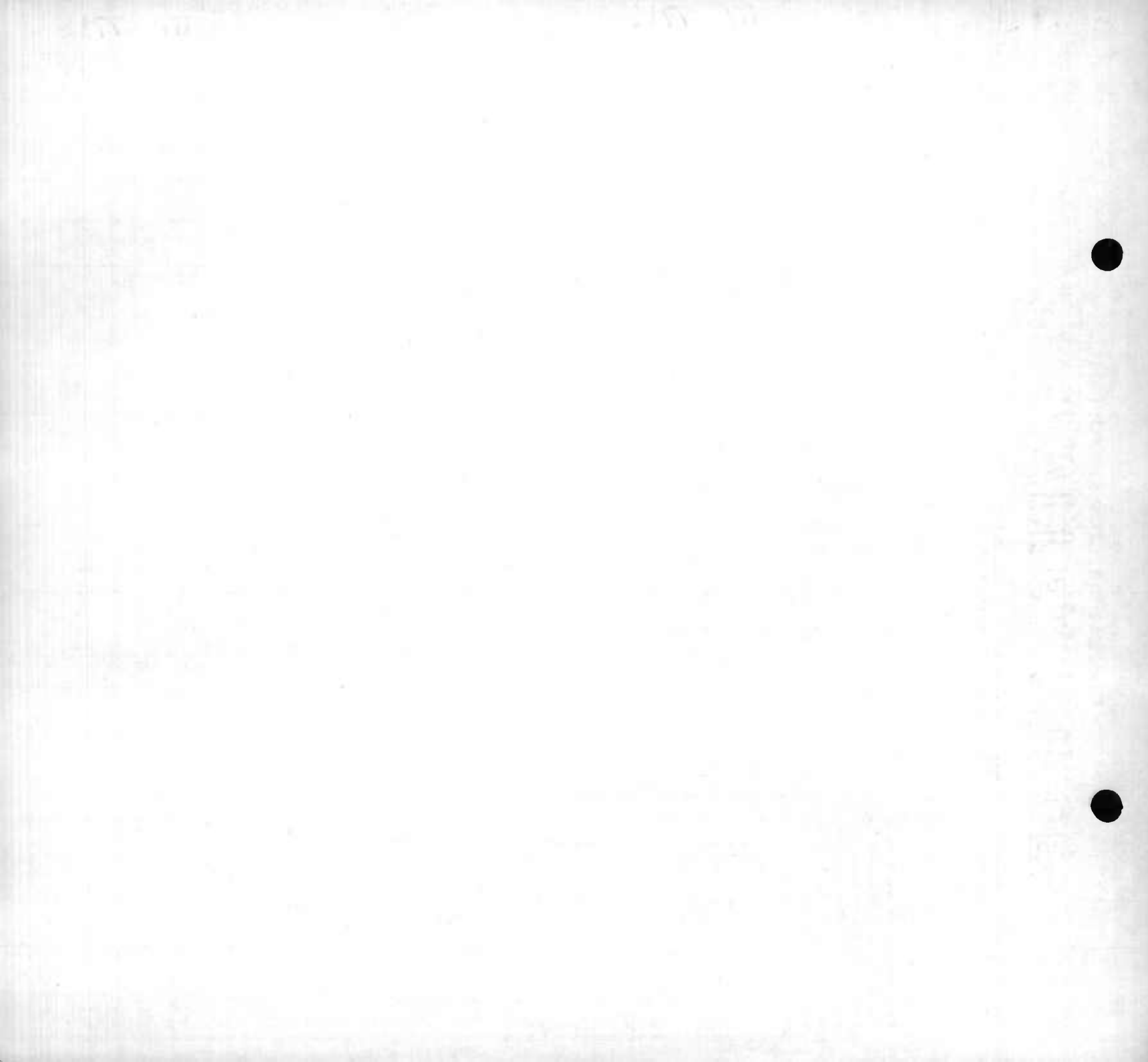
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218

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67-15428 67. 7711					CERTIFICATE OF DEATH					Registered No. 67 7711				
1. NAME OF DECEASED (Type or Print) <i>Eugene Edward Wayland III</i>										2. DATE AND HOUR OF DEATH <i>8/4/67 5:30 AM</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>				
5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>										8. DATE OF BIRTH <i>8/1/67</i>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>										10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>				
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>										12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <i>Eugene Edward Wayland Jr.</i>										14. MOTHER'S MAIDEN NAME <i>Barbara Ann Zameniski</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>										16. SOCIAL SECURITY NO. <i>None</i>				
17. INFORMANT										ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <i>Encephalocoele</i> DUE TO (B) DUE TO (C) DUE TO				
INTERVAL BETWEEN ONSET AND DEATH														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>8-4-67</i>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <i>No</i>										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>8-4-67 8:30 AM</i>										21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <i>8-1-1967</i> to <i>8-4-1967</i> , that (I) (we) last saw the deceased alive on <i>8-4-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Vilma F. Tadalan</i> M.D.										23B. DATE SIGNED <i>8-4-67</i>				
23C. PHYSICIAN'S NAME (Type) <i>VILMA F. TADALAN</i> M.D.										23D. ADDRESS <i>MARYLAND GENERAL HOSPITAL</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>8-9-67</i>										24B. DATE				
24C. NAME OF CEMETERY or CREMATORY										24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 14 1967</i>										25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>				
25C. FUNERAL DIRECTOR										ADDRESS <i>MORTUARY SERVICE - BCHD</i>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7712 4	
BIRTH NO. 67-15317 67 7712		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Girl Phillips		August 7, 1967 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND General Hospital 48		A. STATE MARYLAND B. COUNTY Balto. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 32 Admiral Blvd.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH August 7, 1967
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) -
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S/MAIDEN NAME Daria Banowich	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT		ADDRESS	
18. 759.31		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) multiple congenital anomalies	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION 8-8-67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 7 1967 to 19 that (I) (we) last saw the deceased alive on Aug 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Vilma F. Tadalan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-7-67	
23C. PHYSICIAN'S NAME (Type) VILMA F. TADALAN M.D.		23D. ADDRESS ANATOMY BOARD OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) 8-8-67	24B. DATE	24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967	25B. NAME OF REGISTRAR R. E. Farley	25C. FUNERAL DIRECTOR ADDRESS	

Benjamin Franklin

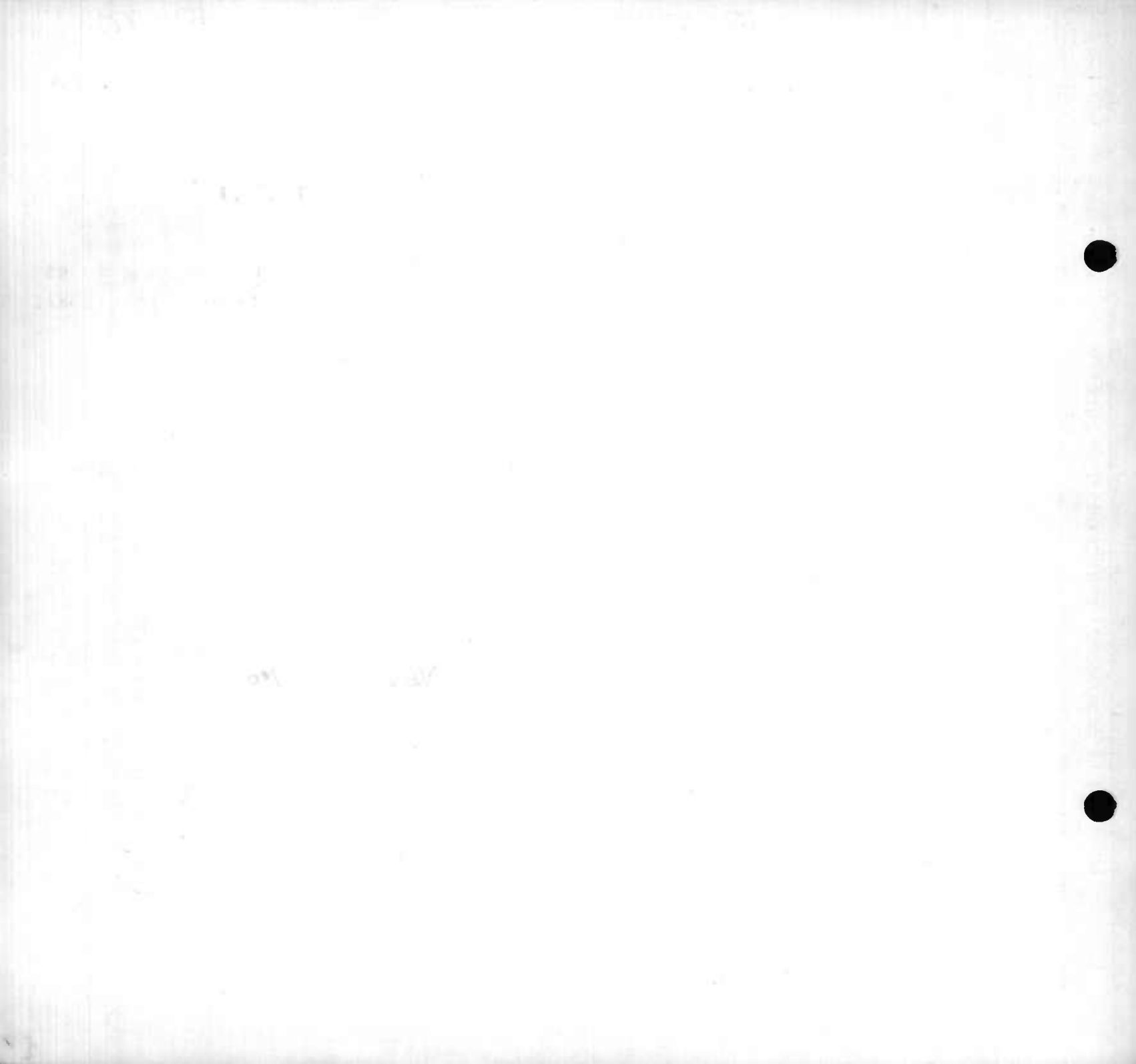
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1757

THE BODY OF LILLIE MAE THORPE WAS RELEASED ON APPROVAL TO THE JOHNS HOPKINS HOSPITAL FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7713				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7713	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LILLIE MAE THORPE				2. DATE AND HOUR OF DEATH 7-26-67 7.30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1437 EAST EAGER STREET 21205 SL 4			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-12-13	9. AGE (In years last birthday) 54	10. CITIZENSHIP If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 56 10-02 10-02 10-02		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 56 10-02 10-02 10-02		
13. FATHER'S NAME JOHN JONES				14. MOTHER'S MAIDEN NAME PEARL WOODS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumococcal Pneumonia INTERVAL BETWEEN ONSET AND DEATH 4 weeks				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ? dys globulinemia			
19A. DATE OF OPERATION 2/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/31 1967 to 7/26 1967, that (I) (we) last saw the deceased alive on 7/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry R. Black				23B. DATE SIGNED 7/26/67		23C. PHYSICIAN'S NAME (Type) HENRY R. BLACK	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-7-67		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS HOSPITAL		24D. LOCATION (City, State, or country) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			



K-352

67 7714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49-87-354
7714

BIRTH NO. 67-15191

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Ketnor Baby Boy - Carolyn

2. DATE AND HOUR OF DEATH

8/4/67 - 8:50 am

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1438 William Street 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

8-4-1967

9. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Carolyn Forrester

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 761.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Asphyxia

(B) DUE TO

Obstetrical trauma

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/4/67 (7am) 19 67 to 8/4/67 (9am) 19 67.
that (I) (we) last saw the deceased alive on 8/4/67 (9am) 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/4/67

23C. PHYSICIAN'S
NAME (Type)

RAQUEL V. MONTEZUMA M.D.

23D. ADDRESS

6058 East Pratt Street
4940 Eastern Avenue, Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Cremated

24B. DATE

8/4/67

24C. NAME of CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION

(City, town, or county)

(State)

4940 Eastern Avenue, Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

25B. NAME OF REGISTRAR

Robert E. Farley, Jr.

25C. FUNERAL DIRECTOR

HOSPITAL DISPOSAL

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W H

What was known

for

What was known
for the first time

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-16730 67 7715		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7715	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Boy REEVES		2. DATE AND HOUR OF DEATH August 4 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3124 27-06 D. STREET ADDRESS (If rural, give location) 6304 Birchwood Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 8-4-67	9. AGE (In years last birthday) 8 8 4	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME George Reeves		14. MOTHER'S MAIDEN NAME Bernice Rutmiller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hospital records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Prematurely (B) DUE TO Viable infant - (C) Pulmonary Atelectasis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/4/67 19 to 8/4/67 19		that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Ewan B. Chambers		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-4-67	
23C. PHYSICIAN'S NAME (Type) EWAN B. CHAMBERS		23D. ADDRESS 3408 ST. PAUL STREET, BALTO MD.		23E. CITY, TOWN, OR COUNTY Baltimore	
23F. STATE MD.		24A. BURIAL CREMATION, REMOVAL (Specify) 8-8-67		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION		24E. CITY, TOWN, OR COUNTY (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCH	

B-420

67 7716 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7716

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH H. BOLLACK, JR.

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1967

9:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex (21)

D. STREET ADDRESS (If rural, give location)

938 Martin Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 4, 1926

9. AGE (in years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lay-out Operator

10B. KIND OF BUSINESS OR INDUSTRY

Western Electric Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Bollack, Sr.

14. MOTHER'S MAIDEN NAME

Grace Spangler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

220 18 7560

17. INFORMANT

Mary Bollack

Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/12/67

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave.

ADDRESS

James (11)

March 1, 1968

Ray-out Operation - Western Electric Co. Baltimore, Md.

Grace Spangler

Joseph Hollock, Jr.

220 15 1900 Ray Hollock same

will

yes

Baltimore, Maryland

and James Spangler

James

1
W-300

67 7717 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7717

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MINNIE

LEE

WYATT

2. DATE AND HOUR PRONOUNCED DEAD

August 10, 1967

7:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Texas

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Levelland

D. STREET ADDRESS (If rural, give location)

2104 Houston Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Jan. 10, 1892

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Kelly

14. MOTHER'S MAIDEN NAME

Susie Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lerria Wyatt 2104 W. Houston St.
Levelland, Texas

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive
Disease
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 13, 1967

23C. NAME of CEMETERY or CREMATORY

City of Levelland Cem.

23D. LOCATION

(City, town, or county)

(State)

Levelland, Texas

24A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

24B. NAME OF REGISTRAR

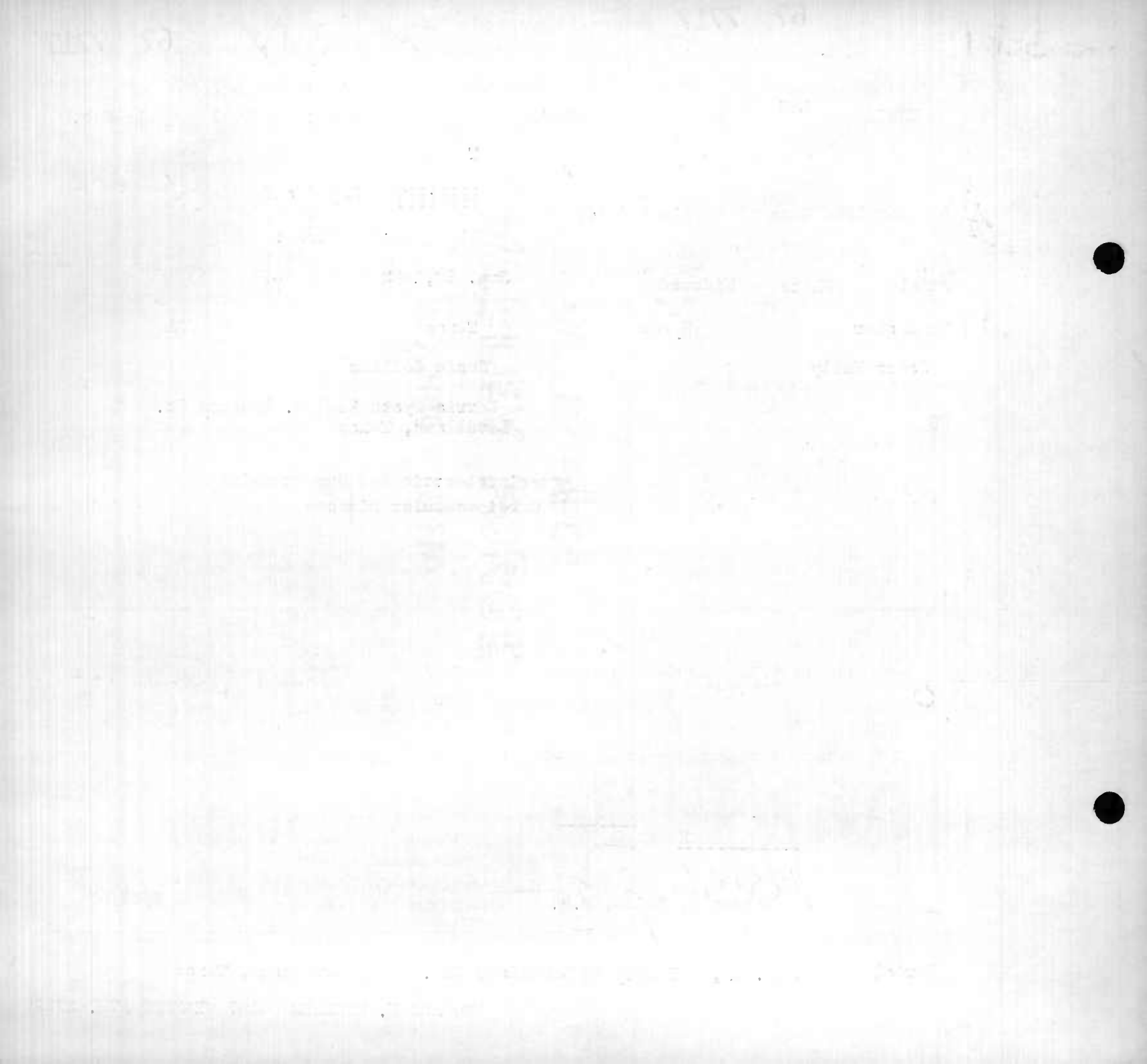
Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

HOWARD H. HUBBARD

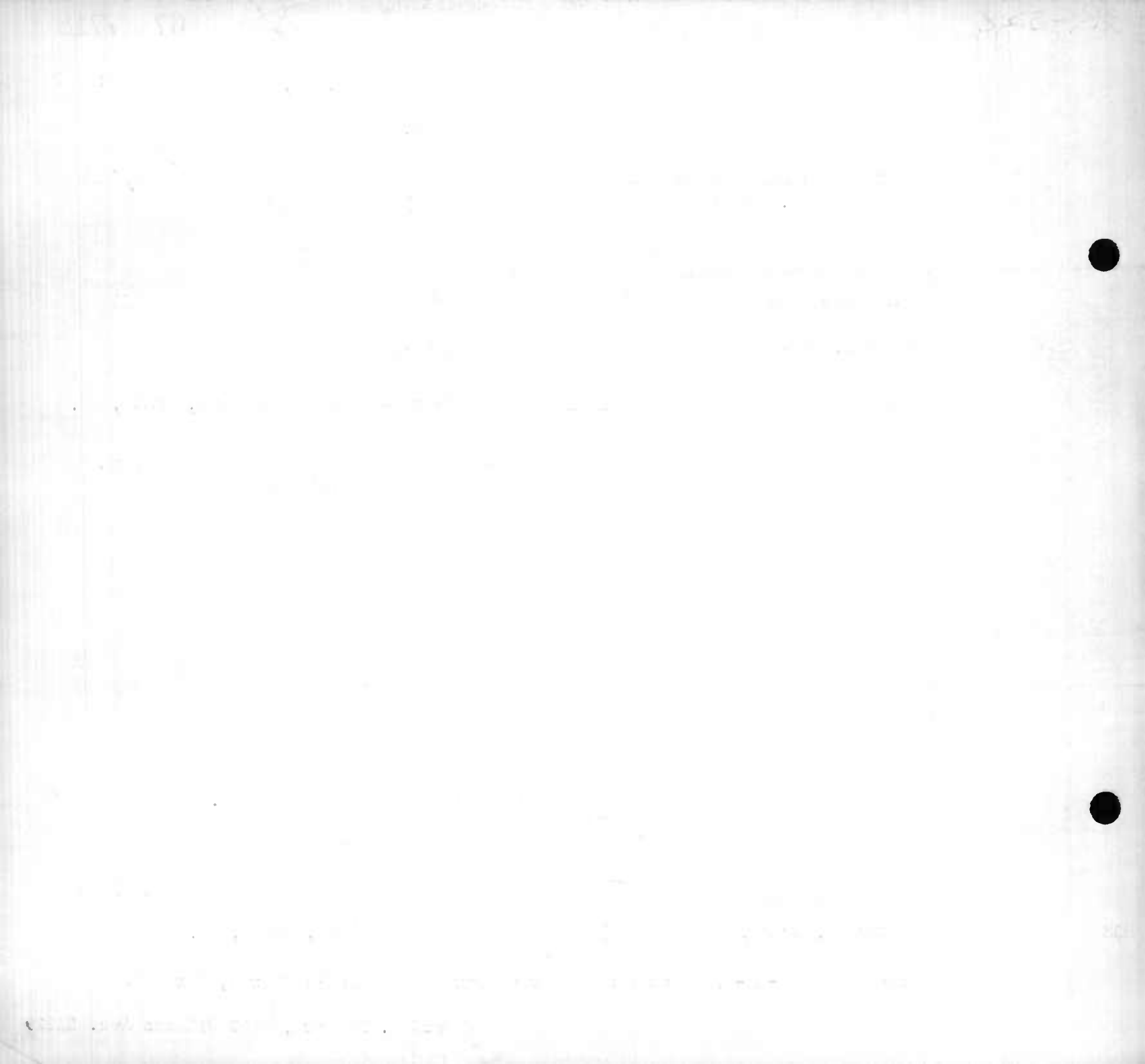
ADDRESS

4107 WILKENS AVE. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7718				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7718	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lillie Marie Ramos				Aug. 10, 1967 4:55 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
US Public Health Service Hospital 3100 Wyman Pk. Drive				Va.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Falls Church			
				D. STREET ADDRESS (If rural, give location)			
				6934 Regent Lane			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.		
F	W	Married	6/16/30	37			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Hwf- sales clerk				DC		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Clyde W. Harris				Mabel Moss			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		578-34-9698		Records- US PHS Hospital, Balto, Md.			
18. 190.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Malignant melanoma with widespread metastases			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (not by medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 18 1967 to Aug. 10 1967, that (I) (we) lost saw the deceased alive on Aug/ 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Henry S. Crist						8/11/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Henry S. Crist, SA Surg (R)				US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-14-67		National Memorial Park		Falls Church, Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1967		Robert E. Fairley		Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

S-310

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7719	
BIRTH NO. 67 7719		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN HERGET STEFF		2. DATE AND HOUR OF DEATH 8-10-67 945 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL Co			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY Hospital Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Linthicum Hqts. Md. 52-00			
		D. STREET ADDRESS (If rural, give location) 606 ANDOVER Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/20/13	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LICENSE INSPTN. -AACO		10B. KIND OF BUSINESS OR INDUSTRY A.A. County		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN L. STIEFF		14. MOTHER'S MAIDEN NAME DORA M. HERGET	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-2425		17. INFORMANT Mrs. Elsie T. Steff (wife) ADDRESS Hospital RECORD Same As #4	
18. 433.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Severe Epistaxis with anemia		72 hrs	
ANTECEDENT CAUSES		(B) Archie arrest Etiology undetermined		1.5 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-8- 19 67 to 8 10 19 67 , that (I) last last saw the deceased alive on 8-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Milton L. Engnoth		M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-10-67	
23C. PHYSICIAN'S NAME (Type) Milton L. Engnoth		M.D. 701 S. Connelley St		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 14/67		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION Glen Burnie, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 14 1967		24F. NAME OF REGISTRAR Robert E. Fairley	
24G. FUNERAL DIRECTOR Singleton Funeral Home		24H. ADDRESS Glen Burnie, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-200

67 7720 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7720

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FRANK

MAYESKI SR.

2. DATE AND HOUR PRONOUNCED DEAD

August 10, 1967 5:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

514 E. Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

514 E. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

10/17/15

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Alexander Mayeski

14. MOTHER'S MAIDEN NAME

Matilda

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.
213-09-319117. INFORMANT (Son) ADDRESS Md. 21222
Frank Mayeski Jr. 8066 Wallace Rd. Dundalk,

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Alteration of Liver
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/15/67

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l. Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

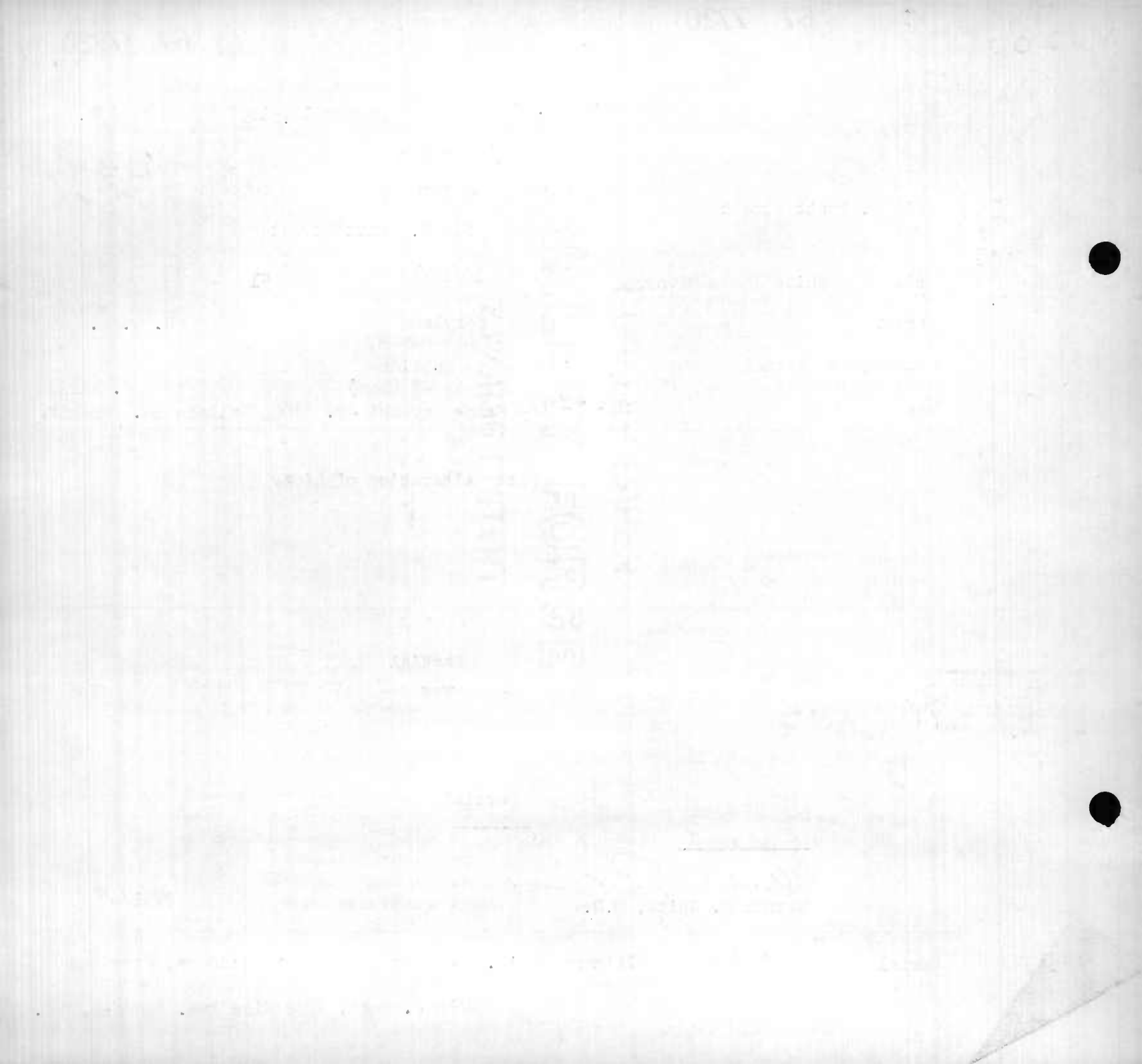
24C. FUNERAL DIRECTOR

ADDRESS

AUG 14 1967

Robert E. Finkbeiner

John J. Duda, 7922 Wise Ave. Dundalk, Md.



49-40-27 DM

5-630

67 7721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 7721

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED SMERWOOD

2. DATE AND HOUR OF DEATH

8-13-67

9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1333 S. Charles St. #21230

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

6-29-29

9. AGE (In years
last birthday)

38

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Designer

10B. KIND OF BUSINESS OR INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John M.

14. MOTHER'S MAIDEN NAME

Dorothy Scott

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCM 4940 Eastern Avenue

RECORDS:

Baltimore, Maryland #21224

18.

201X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Hodgkin's Disease

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/3 1967 to 8/13 1967,
that (I) (we) last saw the deceased alive on 8/13 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. Stan Wilson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/13/67.

23C. PHYSICIAN'S
NAME (Type)

W. STAN WILSON

M.D.

23D. ADDRESS

BCM 4940 Eastern Avenue
Baltimore, Maryland #2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8 16 67

24C. NAME of CEMETERY or CREMATORY

Holy Cross

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave

FUNERAL DIRECTOR: IMPORTANT

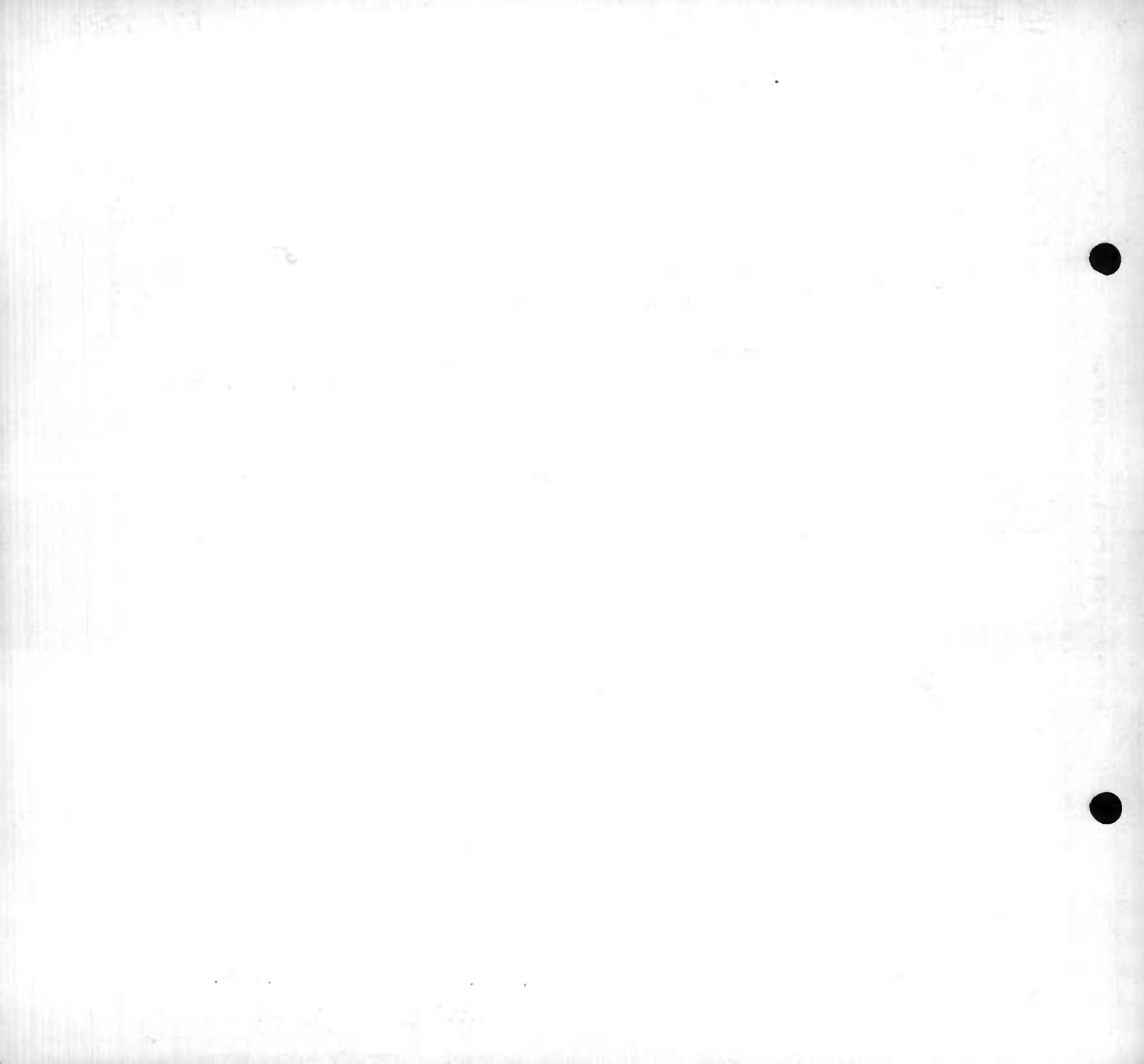
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7722				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7722	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) SAMUEL M. SCHATOFF		2. DATE AND HOUR OF DEATH 8/9/67 5 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3438 Virginia Ave #15			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/4/42	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done, or name of work, or business, even if retired) Refined Guard		10B. KIND OF BUSINESS OR INDUSTRY Crown, Cork & Seal		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JULIUS SCHATOFF				14. MOTHER'S MAIDEN NAME CELENA LEVAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Army 1911		16. SOCIAL SECURITY NO. 2505 2124		17. INFORMANT Ida Schatoff, wife, above ADDRESS MEDICAL CHART			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 450.01 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Uremia DUE TO (B) Generalized arteriosclerosis years DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ?	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/25 19 67 to 8/9 19 67 , that (I) (we) last saw the deceased alive on 8/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. M. Magno M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNO M.D.				23D. ADDRESS FRANKLIN SQUARE HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/11/67	24C. NAME OF CEMETERY OR CREMATORY Jewish War Vet. Mem. Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR R. M. E. F. F. F.		25C. FUNERAL DIRECTOR Schimmek Funeral Home 3331 Brehms Lane #13 ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital where the physician who pronounced death was in regular attendance on the deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
67 7723				67 7723				67 7723			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				LIGHTNER, ADAM EDWARD				August 9, 1967 4:15 p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 House in the Pines				Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore				6-01			
				D. STREET ADDRESS (If rural, give location)				161 N. Decker Avenue, Balto., Md. 21224			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
male		white		widowed		2/10/89		78 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Gauger				Continental Oil Co.				Baltimore, Md.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				Charles Lightner				Catherine Doetzer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
no				213-05-3918				William Lightner, son, 8427 Avery Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				Pneumonia			
ANTECEDENT CAUSES				(B) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Acute cardiovascular disease				4 days.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0				No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 8/8/1967 to 8/9/1967.				that (I) lost saw the deceased alive on 8/8/1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED							
Dr. Albert Bradley				8/11/67							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Dr. Albert Bradley				4900 Belair Road							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		8/12/67		Mt. Carmel Cemetery		Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
AUG 14 1967		Robert E. Farber, M.D.		Schimunek Funeral Home		3331 Brehms Lane #13					

Mr. D. B. B. B.

8/1/02

8/1/02

8/1/02

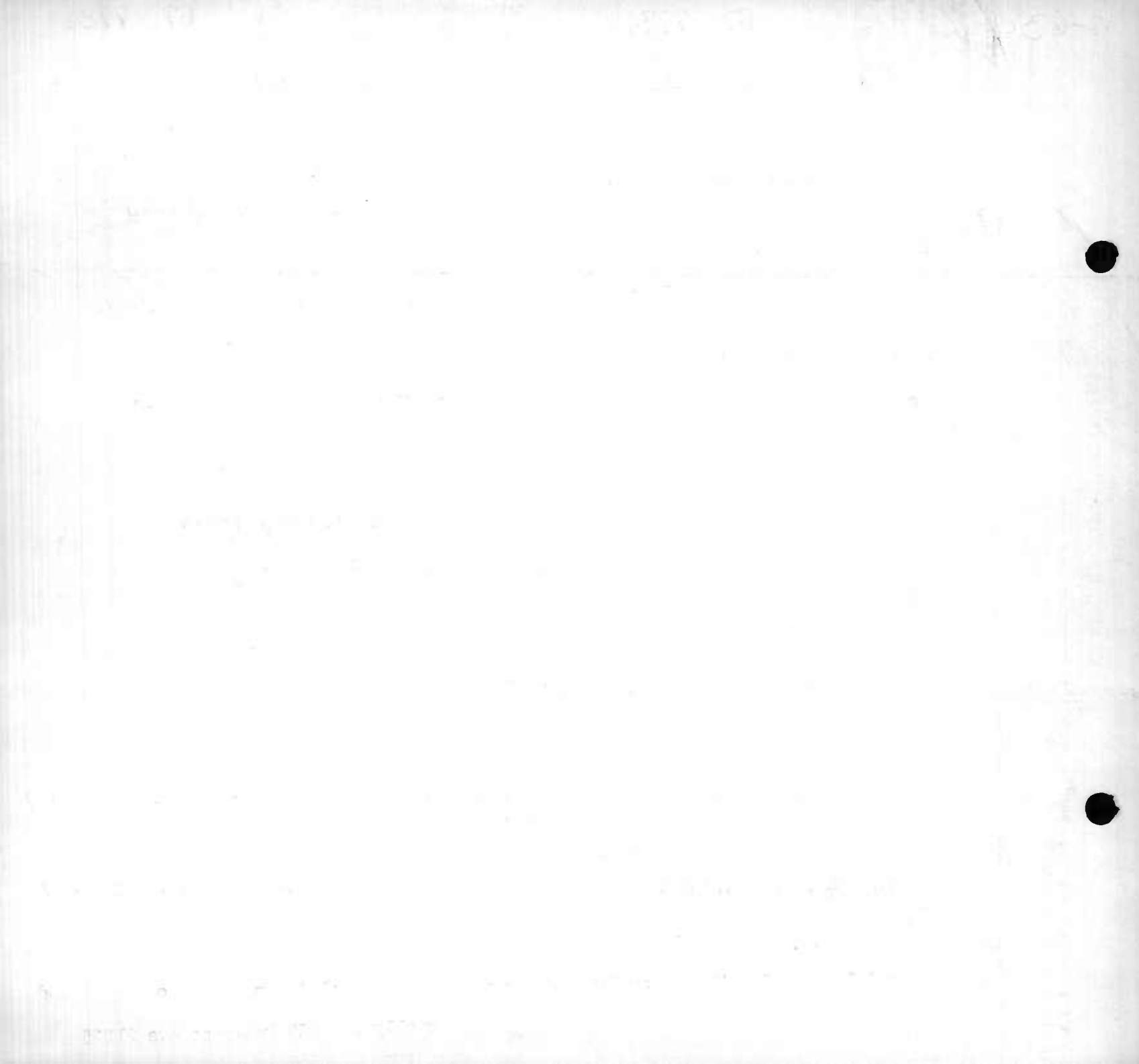
Cent. Conference 4/1/02

2/1/02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7724		67 7724		67 7724	
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED</div> <div>(Type or Print)</div> <div>MARY E. MARTEL</div> </div>					
<div> <div>2. DATE AND HOUR OF DEATH</div> <div>8-12-67</div> <div>8 A. M.</div> </div>					
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> <div>37 MERCY HOSPITAL</div> </div>			<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div>A. STATE</div> <div>B. COUNTY</div> <div>Maryland</div> <div>Balts. Co.</div> </div>		
<div> <div>5. SEX</div> <div>F</div> </div>			<div> <div>6. RACE</div> <div>W</div> </div>		
<div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</div> <div>Never married</div> </div>			<div> <div>8. DATE OF BIRTH</div> <div>5-3-14</div> </div>		
<div> <div>9. AGE (In years last birthday)</div> <div>53</div> </div>			<div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Stenographer</div> </div>		
<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>New York</div> </div>			<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U. S.</div> </div>		
<div> <div>13. FATHER'S NAME</div> <div>John Martel</div> </div>			<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Elizabeth Smyth</div> </div>		
<div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>No</div> </div>			<div> <div>16. SOCIAL SECURITY NO.</div> </div>		
<div> <div>17. INFORMANT</div> <div>Family</div> </div>			<div> <div>ADDRESS</div> <div>Same</div> </div>		
<div> <div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)</div> <div>CAUSE OF DEATH</div> <div>(A) Renal failure; Cardiac Failure</div> <div>DUE TO</div> <div>(B) Carcinoma of small + large bowels</div> <div>DUE TO</div> <div>(C) Carcinoma of the ovary</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>					
<div> <div>19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> <div>Dehydration</div> </div>					
<div> <div>19A. DATE OF OPERATION</div> <div>12-15-65</div> </div>		<div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>Carcinoma of the Ovary</div> </div>		<div> <div>20A. AUTOPSY? (Yes or No)</div> <div>No</div> </div>	
<div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div> </div>		<div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> </div>		<div> <div>21C. WHERE DID INJURY OCCUR?</div> <div>(If in Baltimore City, give exact location)</div> </div>	
<div> <div>21D. TIME OF INJURY (APPROX.)</div> <div>(Month) (Day) (Year) (Hour)</div> </div>		<div> <div>21E. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> </div>		<div> <div>21F. HOW DID INJURY OCCUR?</div> </div>	
<div> <div>22. I certify that (I) (this hospital) attended the deceased from 8-9-1967 to 8-12-1967, that (I) (we) last saw the deceased alive on 8-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> </div>					
<div> <div>23A. SIGNATURE</div> <div>N. Aikins-Afful</div> <div>M.D.</div> </div>				<div> <div>23B. DATE SIGNED</div> <div>8-12-67</div> </div>	
<div> <div>23C. PHYSICIAN'S NAME (Type)</div> <div>DR. HARRY BECK</div> </div>				<div> <div>23D. ADDRESS</div> <div>M.D.</div> </div>	
<div> <div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>		<div> <div>24B. DATE</div> <div>8/16/67</div> </div>		<div> <div>24C. NAME OF CEMETERY or CREMATORY</div> <div>Moreland Mem Park</div> </div>	
<div> <div>24D. LOCATION</div> <div>(City, town, or county)</div> <div>Baltimore Co Md</div> </div>		<div> <div>24E. DATE REC'D BY HEALTH DEPT.</div> <div>AUG 14 1967</div> </div>		<div> <div>24F. NAME OF REGISTRAR</div> <div>Robert E. Finkbeiner</div> </div>	
<div> <div>24G. FUNERAL DIRECTOR</div> <div>McCully F H</div> </div>		<div> <div>24H. ADDRESS</div> <div>237 Patapsco Ave 21225</div> </div>		<div> <div>24I. DATE</div> <div>8-12-67</div> </div>	

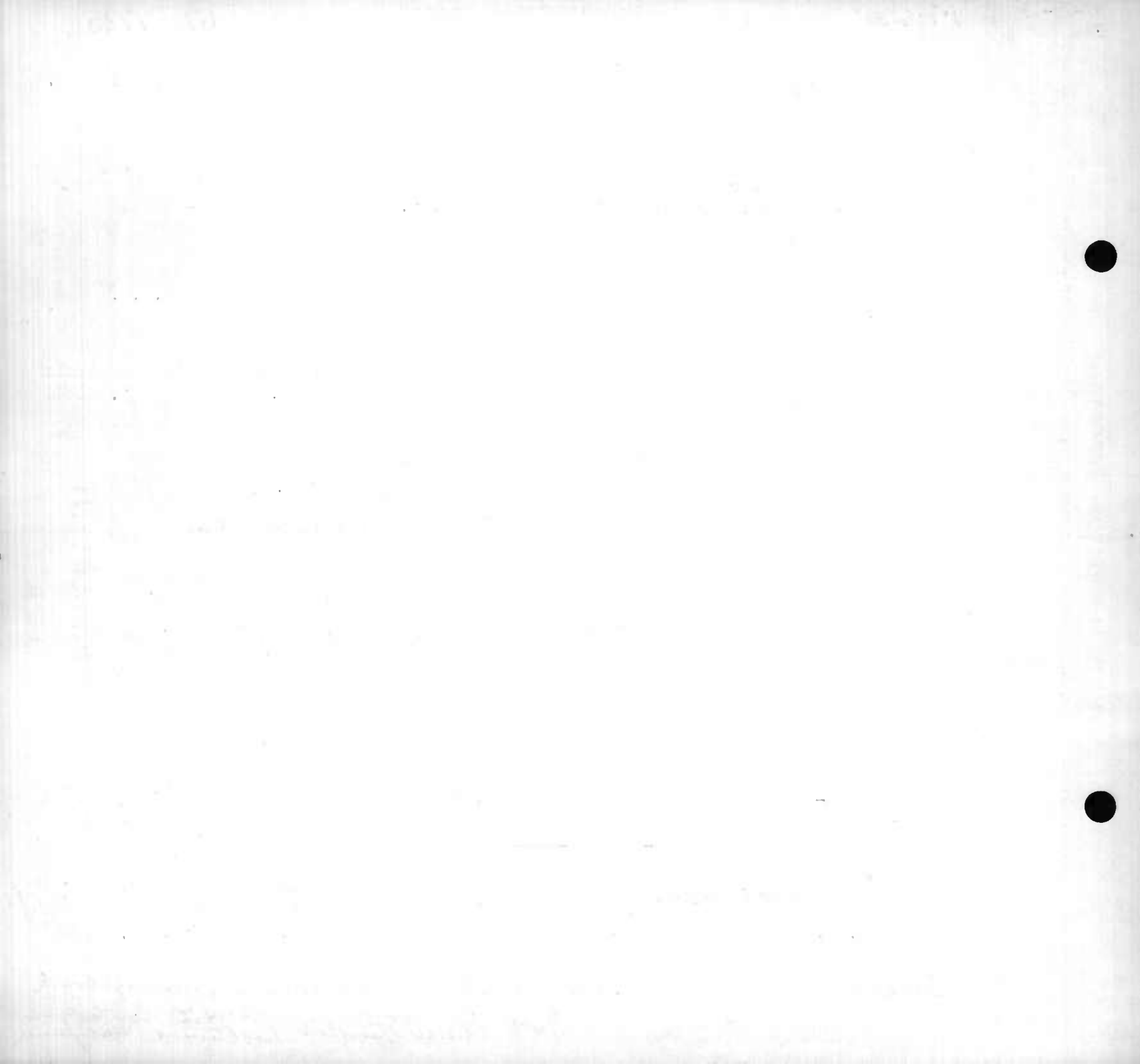


37-25-13
IN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-630 67 7725		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7725	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
MERRITT, Lionell		MERRITT, Lionell		2. DATE AND HOUR OF DEATH	
(Type or Print)		MERRITT, LIONE L		8/10/67 3:10 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
BALTIMORE CITY HOSPITALS		MARYLAND		BALTIMORE	
31 4940 Eastern Avenue		1804 N. COLLINGTON AVENUE - 21213		8-02	
Baltimore, Maryland 21224		5. SEX		6. RACE	
Male		Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
WIDOWED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
7/29/1900		67		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Tobacco Factory		NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		WILLIE MERRITT		NANCY HINTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				RECORDS: Baltimore City Hospitals	
				4940 Eastern Avenue, Baltimore, Md. 21224	
18. 023X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		LUETIC AORTITIS w AORTIC INSUFFICIENCY	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		MASSIVE CARDIOMEGALY	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
MENTAL RETARDATION 2° to CNS LES		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0					
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 8/10 19 67 to 8/10 19 67, that (H) (we) last saw the deceased alive on 8/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
M.S. Tockman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		8/10/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
M. S. TOCKMAN		BALTIMORE CITY HOSPITALS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/14/67		Mt Calvary Cemetery	
24D. LOCATION (City, town, or county)		24E. FURNAL DIRECTOR		24F. ADDRESS	
Baltimore, Maryland		E. E. E. E. E. E.		712-14 E. North Ave	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FURNAL DIRECTOR	
AUG 14 1967		R. E. E. E. E. E.		E. E. E. E. E. E.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

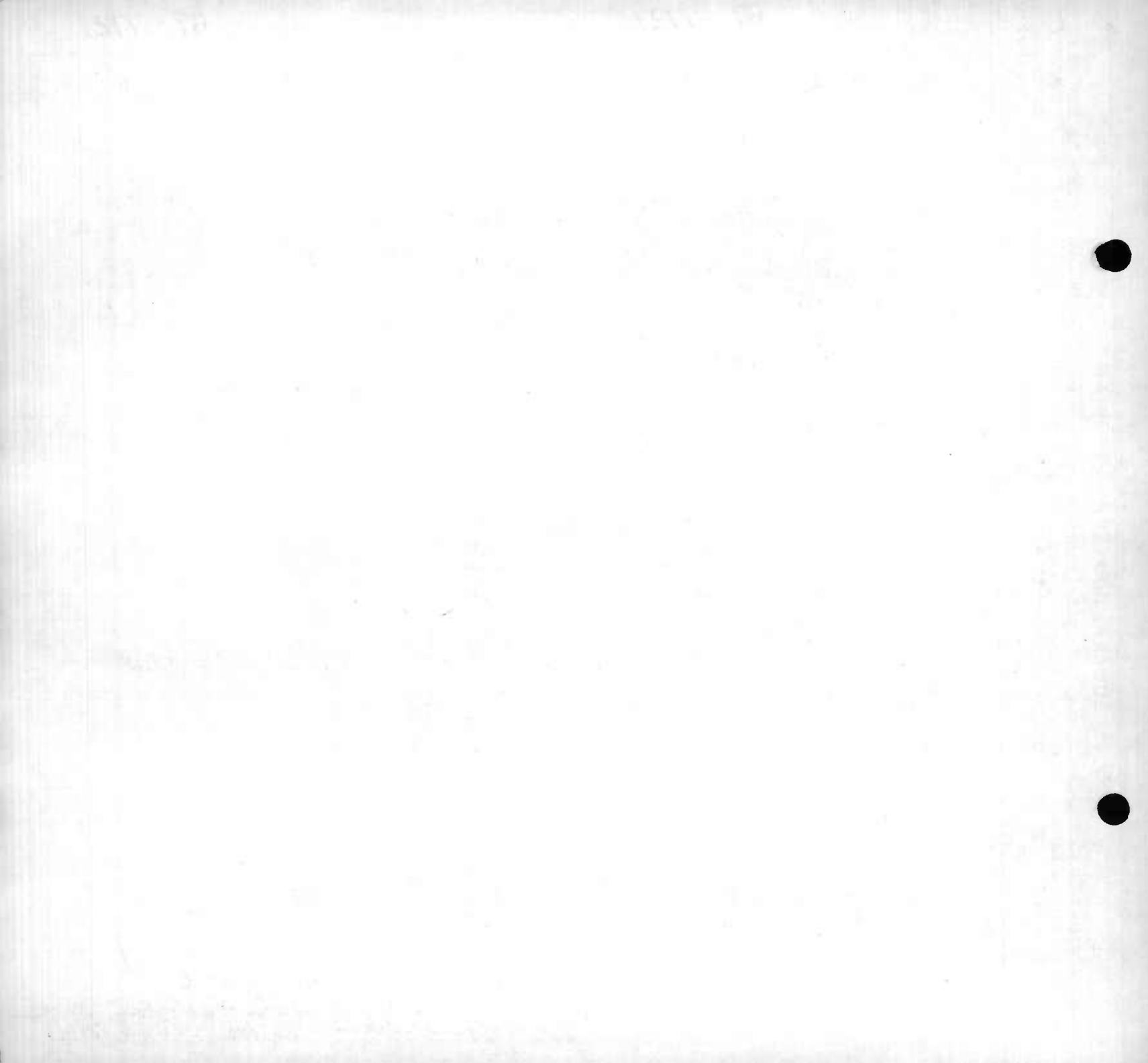
<div style="display: flex; justify-content: space-between;"> 67 7726 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: flex-end;"> Registered No. 67 7726 </div>			
BIRTH NO. _____ M.E. CASE NO. _____ 1. NAME OF DECEASED (Type or Print) LENA HILDEBRANDT		2. DATE AND HOUR OF DEATH AUG. 8, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GOULD NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX D. STREET ADDRESS (If rural, give location) 719 S. MARLYN AVE	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 1887 FEB 1, 1887
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years lost birthday) -85- 80
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID BOHNE		14. MOTHER'S MAIDEN NAME Eliz. Roemer Dishler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____	
17. INFORMANT ELIZABETH FEIT		ADDRESS 717 S. MARLYN	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Central Thrombosis		CAUSE OF DEATH (A) DUE TO _____ (B) DUE TO A.S.O.V.D.- (C) Sub-Acute Hematoma...	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II		INTERVAL BETWEEN ONSET AND DEATH _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____			
19A. DATE OF OPERATION 8/10/67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) _____	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Good Convalesarium	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Nursing Home	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? Fall- Down From Bed.	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on 8/8/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Andrew M. Allie		23B. DATE SIGNED 8/10/67	
23C. PHYSICIAN'S NAME (Type) Andrew M. Allie		23D. ADDRESS 5155 Pica Branch Blvd. #1,304 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/11/67	24C. NAME OF CEMETERY or CREMATORY PARKWOOD	24D. LOCATION (City, town, or county) (State) BALTO. MD
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	

Baptismal Record from Emanuel German Reformed
Church and V.S. 153 8-25-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

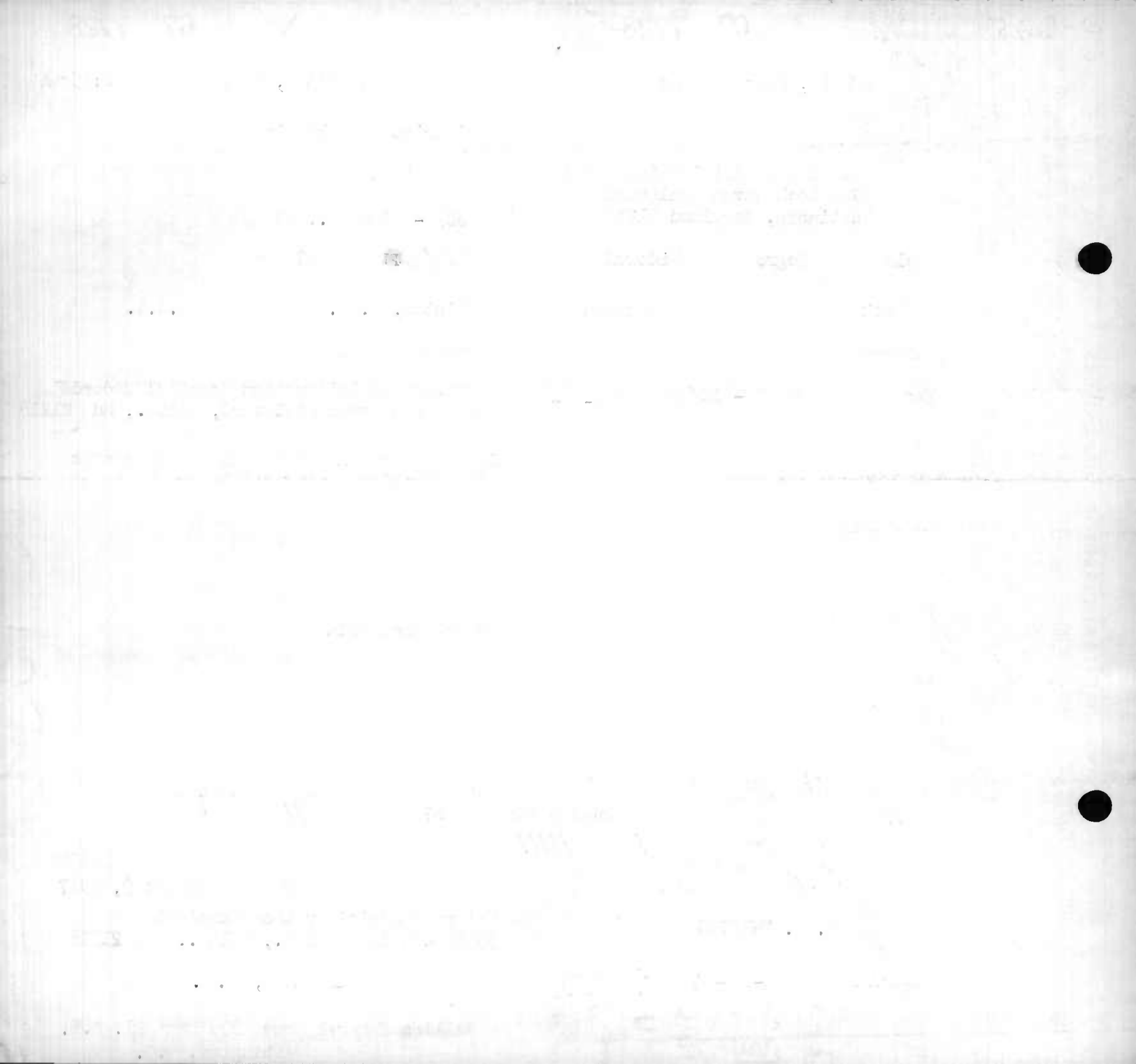
BIRTH NO. 67 7727		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7727	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA KARCAUSKAS (ona)		2. DATE AND HOUR OF DEATH 8/9/67 8:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Franklin Square Hospital		Maryland		Baltimore	
6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow		8. DATE OF BIRTH 3/11/87	
9. SEX F		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				Lithuania	
13. FATHER'S NAME ? SAWICKI		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216 10 7767		17. INFORMANT Medical chart	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Infarction		2 wks	
ANTECEDENT CAUSES		(B) Generalized arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5 1967 to 8/9 1967, that (I) (we) lost saw the deceased alive on 8/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond S. Magno M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNO M.D.	
23D. ADDRESS FRANKLIN SQUARE HOSP		23E. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNO M.D.		23F. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8-14-67		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	
24D. LOCATION (City, town, or county) (State) Balto. 25. Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 14 1967		24F. NAME OF REGISTRAR Robert E. Farber	
24G. DATE REC'D BY HEALTH DEPT. AUG 14 1967		24H. NAME OF REGISTRAR Robert E. Farber		24I. FUNERAL DIRECTOR J. N. Hahn	
24J. ADDRESS 4200 Pennington Ave		24K. ADDRESS Balto. 21226, Md.		24L. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7728	
BIRTH NO. 67 7728		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DUNCAN, Jesse Thomas			2. DATE AND HOUR OF DEATH August 8, 1967 6:25 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE District of Columbia B. COUNTY Washington		
FULL NAME OF HOSPITAL OR INSTITUTION 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington		
			D. STREET ADDRESS (If rural, give location) 809 - 52nd St., NE		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/4/05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Clinton, S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Duncan			14. MOTHER'S MAIDEN NAME Fannie Wright		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes 11/25/42 - 10/2/45		16. SOCIAL SECURITY NO. 577-10-9857	17. INFORMANT ADDRESS Veterans Administration Hospital Records 3900 Loch Raven Boulevard, Balto., Md 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of tonsil and tongue with extension			INTERVAL BETWEEN ONSET AND DEATH 14 months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Bronchopneumonia		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 13th 1967 to August 8th 1967 , that (I) (we) last saw the deceased alive on August 8th 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. A. Twining				23B. DATE SIGNED August 9, 1967	
23C. PHYSICIAN'S NAME (Type) R. H. TWINING				23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-13-67	24C. NAME OF CEMETERY or CREMATORY Springfield Church Cemetery	24D. LOCATION (City, town, or county) (State) Clenton, S.C.		
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Rollins Funeral Home 4339 Hunt Pl. N.E. Washington, D.C.		

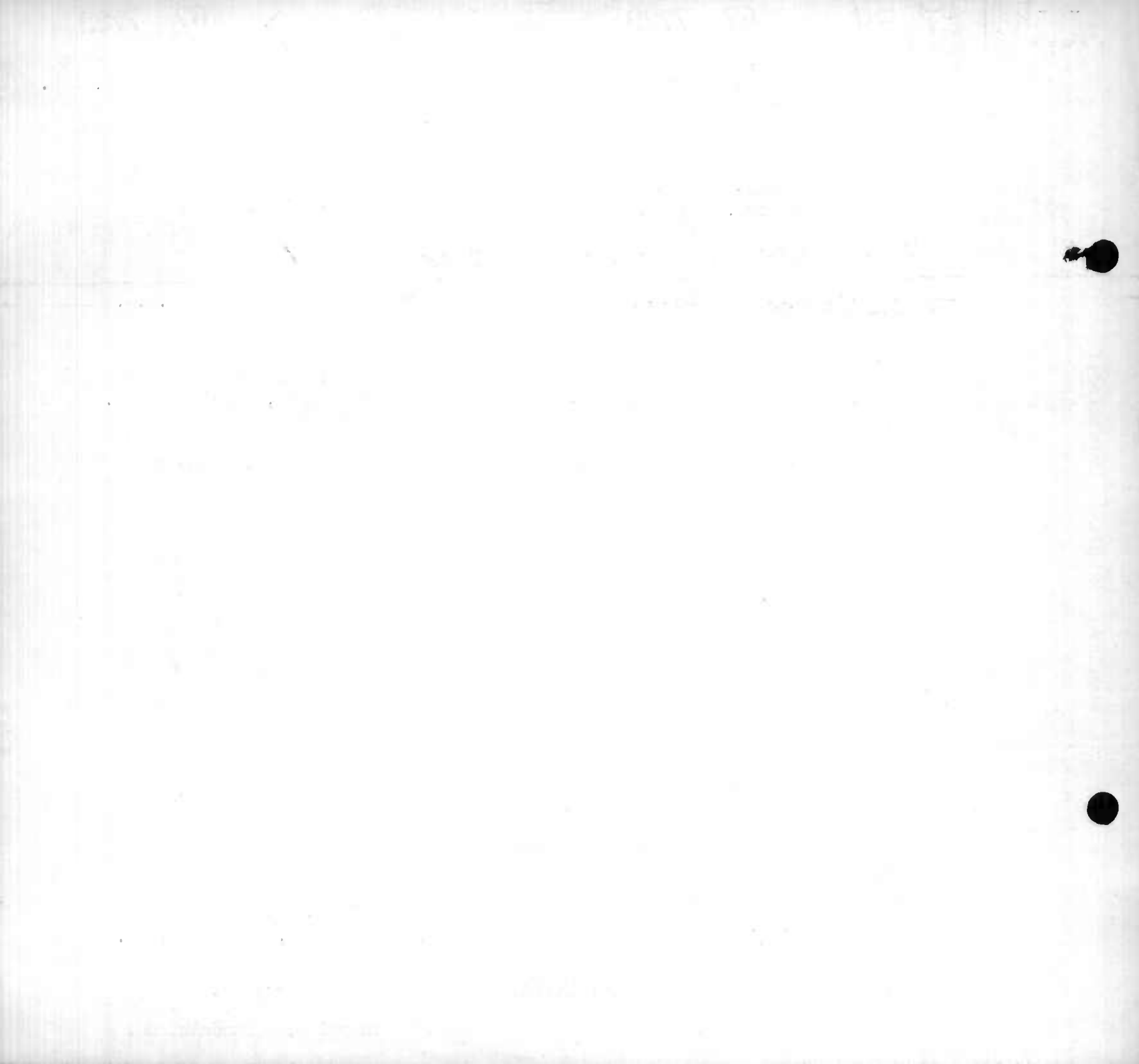


48-68-85
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

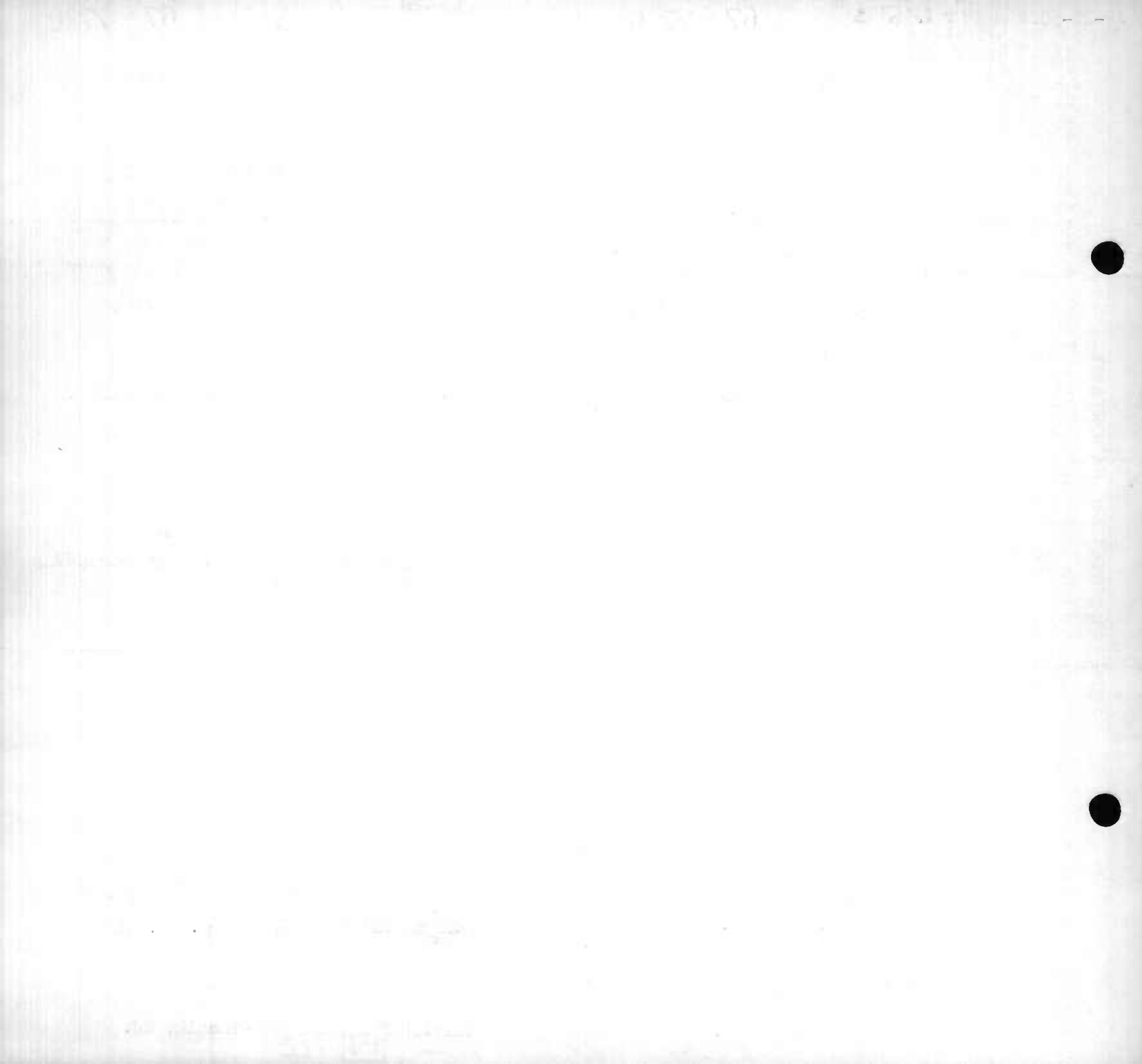
BIRTH NO. 67 7729		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7729	
M.E. CASE NO.		1. NAME OF DECEASED CIFE, John		2. DATE AND HOUR OF DEATH 8/9/67 10:30 P. M.	
(Type or Print) CIFE, JOHN					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				D. STREET ADDRESS (If rural, give location) 115 WOODLAND AVENUE - 21222	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 12/28/95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIN MILL WORKER		10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) EUROPE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-2642		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH PROB. VENTRICULAR ARRHYTHMIA		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		SUBCLOTTIC STENOSIS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 8/9/ 19 67 to 8/9/ 19 67, that (X) (we) last saw the deceased alive on 8/9/ 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE M.S. Tockman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) M. S. TOCKMAN		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/67		24C. NAME of CEMETERY or CREMATORY Sacred Heart,	
				24D. LOCATION Dundalk, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

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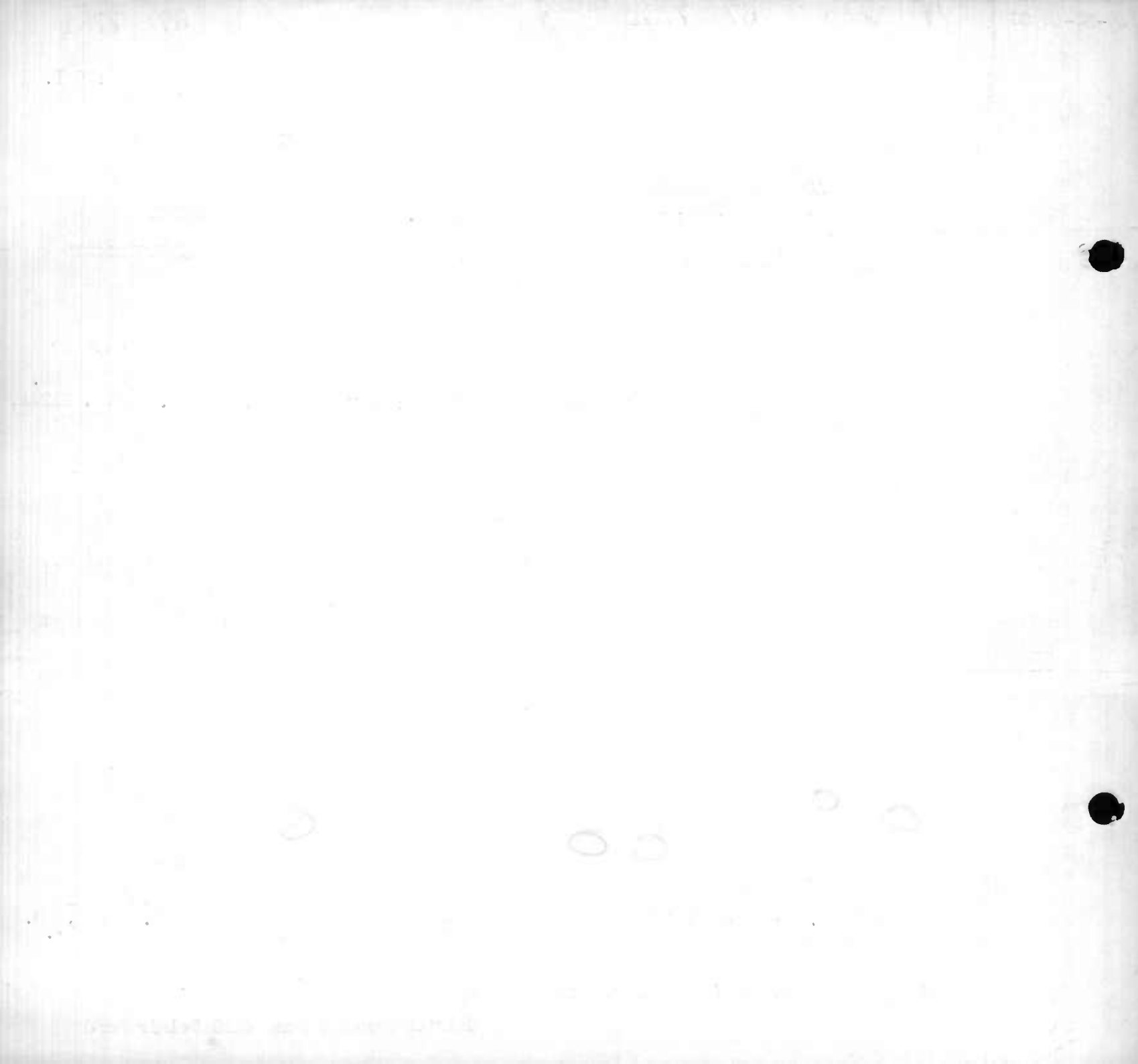
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				TITO FERRANTE		8/10/67 - 11 ²⁰ PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				MD MARYLAND BALTIMORE COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
BALTIMORE				24 AVON AVE 21222			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	WHITE	UNKNOWN	2/15/84	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
UKN		UKN		UKN		UKN	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UKN				UKN.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
?		219-32-6334		BCM: RECORDS		4940 EASTERN AVENUE 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
43411				Acute Pulmonary Edema			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) Congestive Heart Failure - 3 months Etiology Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from on 8/10/67 19 to 19, that (1) (we) last saw the deceased alive on 8/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
David E. McBeth						8/10/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. DAVID E. MC BETH DAVID F. MCBETH				4940 EASTERN AVENUE BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/14/67		Meadow Ridge		Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1967		Robert E. Farley, MD		Ullrich Funeral Home Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

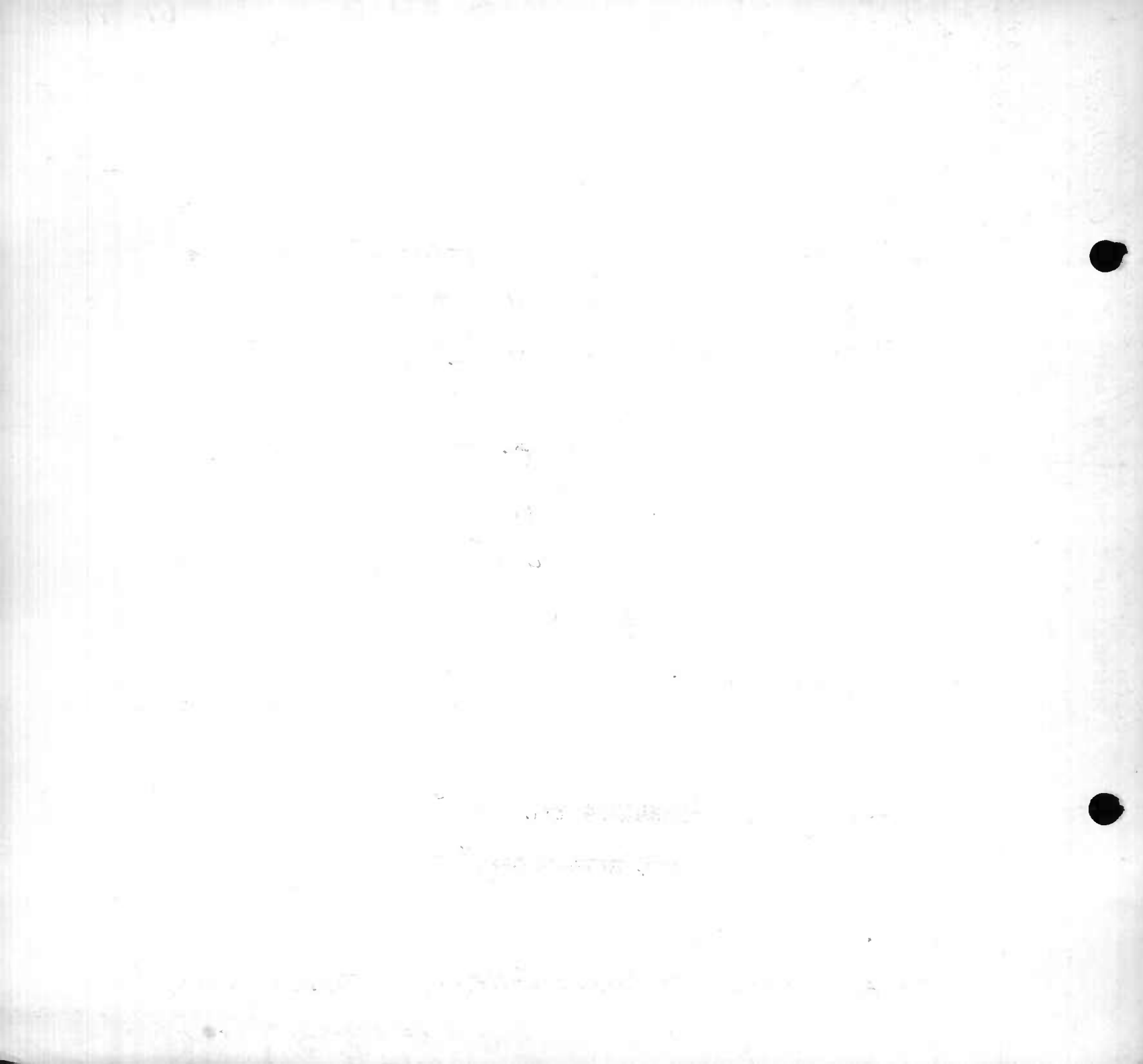
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) LOUISA HESSE		2. DATE AND HOUR OF DEATH 5:15 PM 8/11/67 5:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co.	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 381 BALTIMORE EASTERN AVENUE BALTIMORE 21224, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00	
D. STREET ADDRESS (If rural, give location) 338 E. RIVERSIDE ROAD 21221			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/10/86
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM RENTSCHLER		14. MOTHER'S MAIDEN NAME ANNA MARIE GROSSMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-4069 A	
17. INFORMANT RECORDS DEPT		ADDRESS MD. 4940 EASTERN AVE. BALTO. 21224,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) ASPIRATION PNEUMONIA DUE TO (B) CVA DUE TO (C) ASCVD & cerebrovascular disease long standing.	
INTERVAL BETWEEN ONSET AND DEATH 7 days 13 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/8 to 8/11 19 67 to 8/11 19 67, that (I) (we) last saw the deceased alive on 8/11 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leonard Lippman M.D.		23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) DR. LEONARD LIPPMAN		23D. ADDRESS BALTIMORE CITY HOSPITALS BALTO. 21224, MD. 4940 EASTERN AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/67	
24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Ulrich Funeral Home		ADDRESS 4210 Belair Road	



RELEASED with Approval of Med. EXAMINERS
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 4-554 67 7732		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7732	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LUMINELLO ERNEST A.		2. DATE AND HOUR OF DEATH 10 Aug. 67 4:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND BALTIMORE, Md. 21201		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New Jersey B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) HASTBROUCK HTS. V-27 D. STREET ADDRESS (If rural, give location) 188 OLDFIELD AVE.			
5. SEX ♂	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9-29-25	9. AGE (In years lost birthday) 41	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTING PRESSMAN		10B. KIND OF BUSINESS OR INDUSTRY WILKITA Box Co.		11. BIRTHPLACE (State or foreign country) P. I.	
13. FATHER'S NAME CARMEN LUMINELLO (dec)		14. MOTHER'S MAIDEN NAME ANGELINA BARONE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RHEUMATIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. MITRAL INSUFFICIENCY & STENOSIS PULMONARY HYPERTENSION, SEVERE		CAUSE OF DEATH RHEUMATIC HEART DISEASE MITRAL INSUFFICIENCY & STENOSIS PULMONARY HYPERTENSION, SEVERE		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10 Aug. 67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED A & B		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-4 1967 to 10 Aug 1967 , that (I) (we) last saw the deceased alive on 10 aug 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Miquel Gonzalez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10 Aug. 67	
23C. PHYSICIAN'S NAME (Type) Dr. Miquel Gonzalez		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG-67		24C. NAME of CEMETERY or CREMATORY ST. MARV'S CEMETERY	
24D. LOCATION (City, town, or county) (State) JADDLE BROOK, N.J.		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME 424 BELMONT AVE HASTBROUCK HTS. N. J.			



F-3251

67 7733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 7733

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FITZMAURICE, ANNA MARIE

2. DATE AND HOUR OF DEATH

AUGUST 10, 1967

3:15P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

ST. AGNES HOSPITAL

(If not in hospital or institution, give street
address or location)WILKENS & CATON AVES.
BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

21229

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1119 HAVERHILL ROAD

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

01-05-91

9. AGE (In years
lost birthday)

76

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOMEMAKING

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ALOIS--- Frietch

DEC'D

14. MOTHER'S MAIDEN NAME

UNKNOWN

Sophie - - -

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

NO

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Mrs. Helen W. Schmelyun WILKENS & CATON
1536 Sulphur Spring Rd
ST. AGNES RECORDS - BALTIMORE, MD.

ADDRESS

18.

157 XI 260X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A)
DUE TO

Carcinoma of the Pancreas

(B)
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~X~~ (this hospital) attended the deceased from JULY 22, 19 67 to AUGUST 10, 19 67.
that ~~X~~ (we) lost saw the deceased alive on AUGUST 10, 19 67 and that ~~XX~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~X~~ (We) (did) ~~XXXX~~ view the body after death.

23A. SIGNATURE

G. Braun

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/10/67

23C. PHYSICIAN'S
NAME (Type)

GABRIELA BRAUN, M.D.

M.D.

23D. ADDRESS

ST. AGNES HOSPITAL - BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/14/67

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-11-58

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

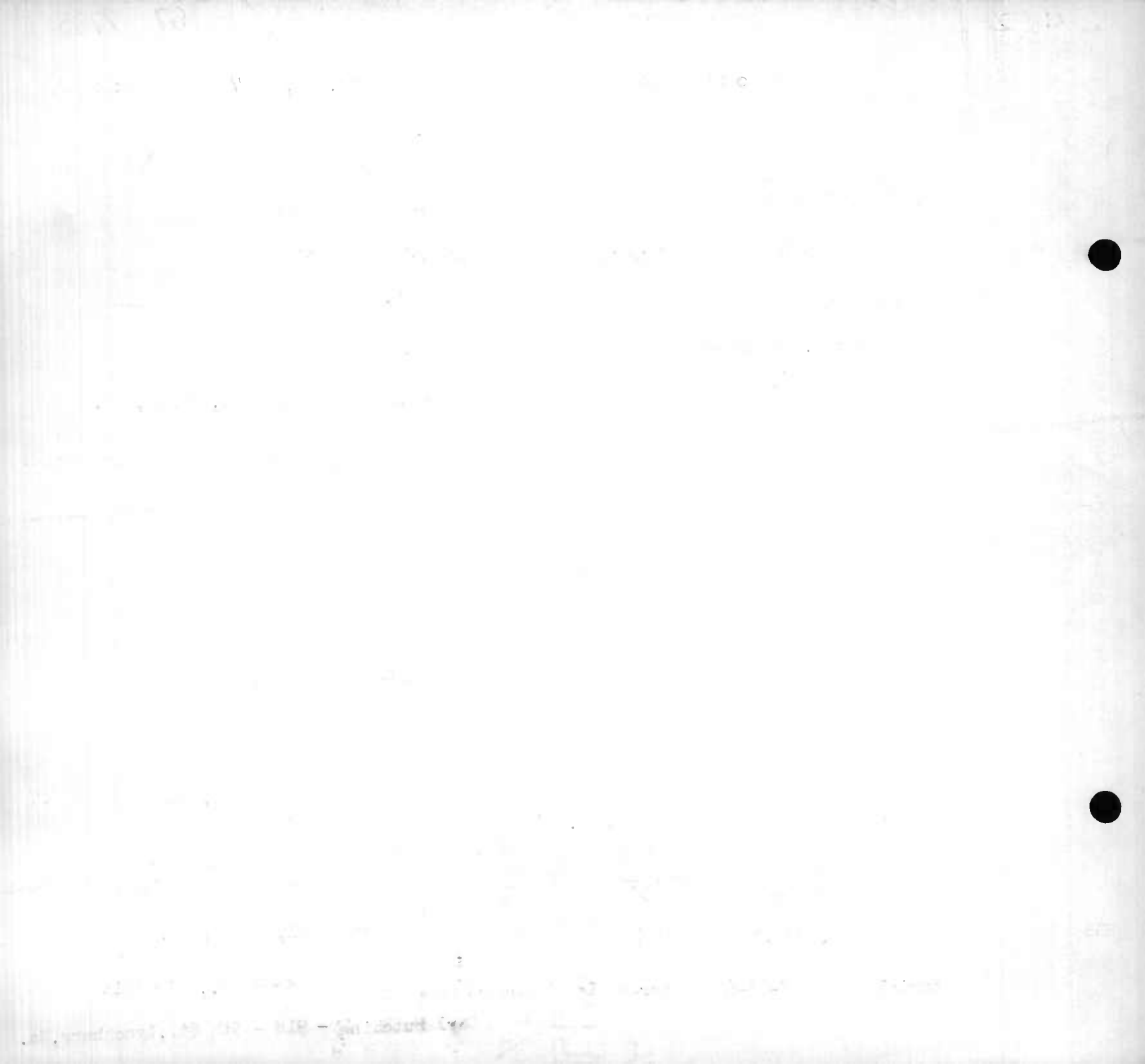
BIRTH NO.		67 7734		Baltimore City Health Department		Registered No. 67 7734	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) COLEMAN Mrs. ELLEN B.			
2. DATE AND HOUR OF DEATH 8-11-1967 10²⁵ P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 2224. CALLOW AVENUE		13-02	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5-3-1900	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RALPH H. LAWRENCE MORRIS COLEMAN SR.				14. MOTHER'S MAIDEN NAME MARY PAGE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MORRIS COLEMAN JR.		ADDRESS 2224. CALLOW AVE. BALTIMORE MD.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) THROMBOSIS		CAUSE OF DEATH (A) BILATERAL CEREBRAL (B) ARTERIOSCLEROTIC C-V. DISEASE (C) HYPERTENSIVE C-V DISEASE		INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS		MANY YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-21-1967 to 8-11-1967 , that (I) (we) last saw the deceased alive on 8-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Zin U. Park				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-11-67	
23C. PHYSICIAN'S NAME (Type) ZIN UO PARK				23D. ADDRESS MONTEBELLO STATE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-67		24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR W. A. McFarland		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Avenue	



1940-1941
1940-1941
1940-1941

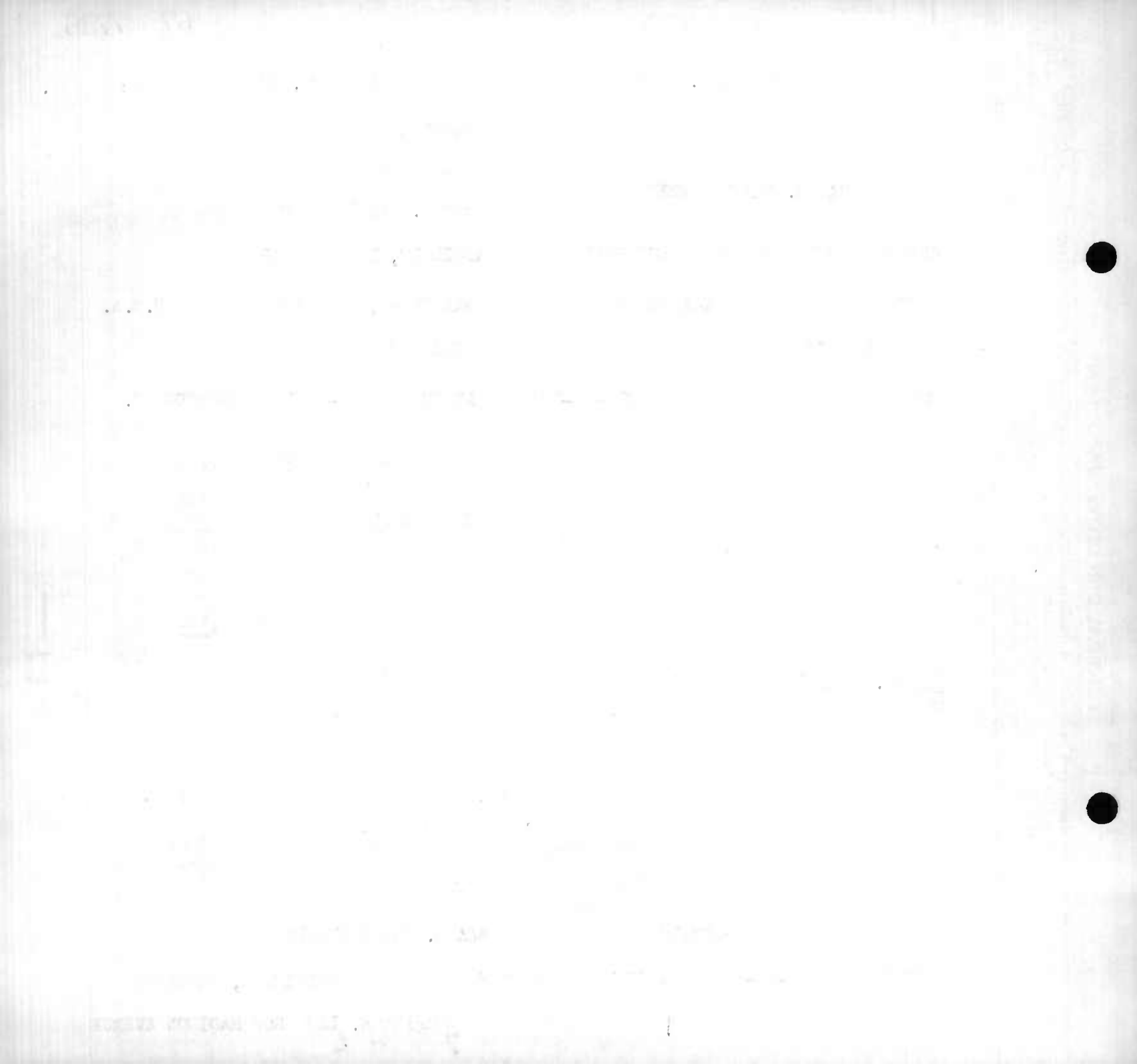
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7735				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7735	
1. NAME OF DECEASED (Type or Print) George Donald Williams				2. DATE AND HOUR OF DEATH Aug. 10, 1967 8:15 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lynchburg D. STREET ADDRESS (If rural, give location) 701 Madison Street			
5. SEX M	6. RACE Col	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8/1/34	9. AGE (In years last birthday) 33	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Loxie R. Williams				14. MOTHER'S MAIDEN NAME Susie Campbell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. 207.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYELOGENOUS LEUKEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Acute myelogenous leukemia (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Several weeks	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 29 1967 to Aug. 10 1967, that (I) (we) lost saw the deceased alive on Aug. 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry S. Crist				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surg (R)				23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-67		24C. NAME of CEMETERY or CREMATORY Forest Level Church Cemetery		24D. LOCATION (City, town, or county) (State) Bedford Co., Virginia	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Carl Hutchins - 918 - 5th St., Lynchburg, Va.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

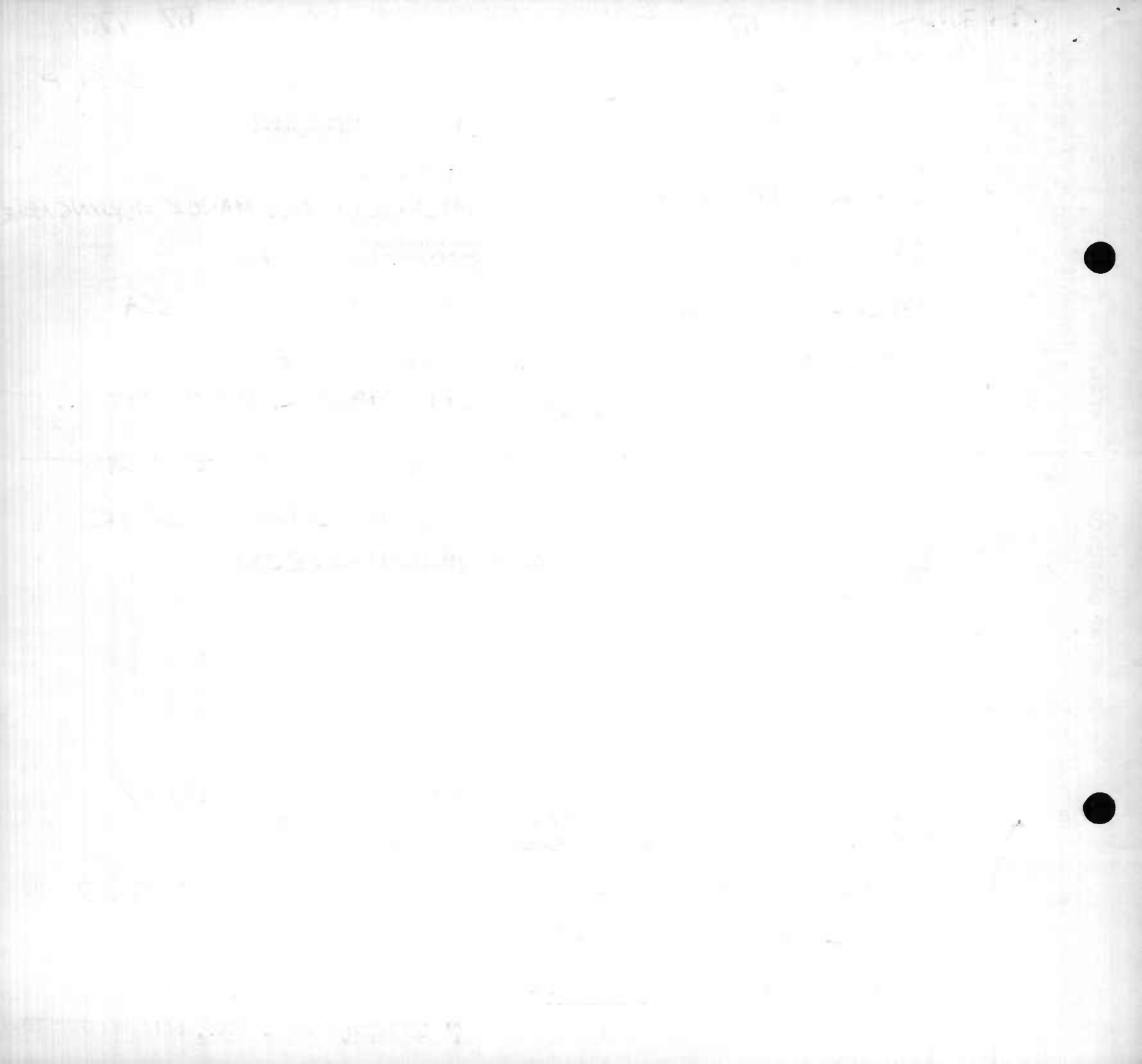
BIRTH NO. 67 7736				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7736	
1. NAME OF DECEASED (Type or Print) EVELYN M. SEAY				2. DATE AND HOUR OF DEATH AUGUST 9, 1967 7:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 844 N. CAREY STREET				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-02 D. STREET ADDRESS (If rural, give location) 844 N. CAREY STREET			
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH APRIL 27, 1918	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY DOCTORS OFFICE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUCIUS MINOR				14. MOTHER'S MAIDEN NAME MARY DISHMOND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-10-2548		17. INFORMANT ADDRESS LUCIUS MINOR - 1817 ASHBURTON ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 151X I CAUSE OF DEATH (A) Lobar Pneumonia, left base DUE TO (B) Gastric Carcinoma DUE TO (C) ? INTERVAL BETWEEN ONSET AND DEATH 3 days							
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION Dec. 23, '66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Obstruction		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 22, 1966 to August 9, 1967 , that (I) (we) last saw the deceased alive on August 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George McDonald				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) GEORGE McDONALD				23D. ADDRESS M.D. 844 N. CAREY STREET			
24A. BURIAL CREMATION, ETC. (Specify) BURIAL		24B. DATE 8-12-67		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR CHARLES R. LAW		ADDRESS 802 MADISON AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7737	
BIRTH NO. 67 7737		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Max Mazer	
2. DATE AND HOUR OF DEATH 8/9/67 2:31 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp		A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO D. STREET ADDRESS (If rural, give location) MILFORD MILL MANOR NURSING HOME	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 8/9/27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING	9. AGE (In years last birthday) 90
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BEN ZION MAZER		14. MOTHER'S MAIDEN NAME BRVNA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-1788	17. INFORMANT ADDRESS WM. MAZER, 4402 OLD COURT RD., APT 2
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) CONGESTIVE HEART FAILURE 2 DAYS	
ANTECEDENT CAUSES		(B) DIABETES MELLITUS 20 YRS	
		(C) GEN ARTERIOSCLEROSIS	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/7/67 to 8/9/67 that (we) last saw the deceased alive on 8/9/67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.			
23A. SIGNATURE Edward R. Cohen M.D.		23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) EDWARD R. COHEN M.D.		23D. ADDRESS Sinai Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/11/67	24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH-AITZ CHAIM	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Johnson	
		25C. FUNERAL DIRECTOR SQL LEVINSON & BROS. INC., 6010 REISTERSTOWN	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7739				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7739	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
S.				HERMAN RICHMAN ^{Richman}		10 August 1967 12:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY	
SINAI HOSPITAL				MARYLAND			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M				W		NEVER MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
EMPLOYEE				STATE OF MARYLAND		SEPT. 1901	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
ISAAC RICHMAN				RACHEL ?		64	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
YES W.W. 11 ARMY				219-16-9253		MRS. BESSIE RICHMAN, 3708 DENNLIN ROAD #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)				(A) SEPTICEMIA, BRONCHOPNEUMONIA		20 DAYS	
ANTECEDENT CAUSES				(B) CEREBROVASCULAR ACCIDENT		20 DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) MYOCARDIAL INFARCTION		20 DAYS	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 22 JULY 19 67 to 10 August 19 67, that (I) last saw the deceased alive on 10 August 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
BARRY M. POTTER				10 Aug 1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
BARRY M. POTTER				SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL				8/11/67		BNAI ISRAEL	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 14 1967				R. L. B. & J. L. B.		6010 ADDRESS	
						SOZ LEVINSON & BROS. INC., REISTERSTOWN	

8/16/67 - Form from funeral director.

NBC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7740	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 7740</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) JACOB, ANTHONY JOHN</p> </div> <div> <p>2. DATE AND HOUR OF DEATH AUGUST 10, 1967 10:50 P M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <div style="display: flex; justify-content: space-between;"> <div> <p>FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVES. BALTIMORE, MD. 21229</p> </div> <div> <p>(If not in hospital or institution, give street address or location)</p> </div> </div>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <div style="display: flex; justify-content: space-between;"> <div> <p>A. STATE MARYLAND</p> <p>B. COUNTY 21223</p> </div> <div> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 349 S. STRICKER STREET</p> </div> </div>		
<p>5. SEX MALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED</p>	<p>8. DATE OF BIRTH 9-11-98</p>	<p>9. AGE (In years last birthday) 68</p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN</p>	<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>
<p>13. FATHER'S NAME LOUIS JACOB DEC'D</p>			<p>14. MOTHER'S MAIDEN NAME UNKNOWN DEC'D</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) YES UNKNOWN</p>		<p>16. SOCIAL SECURITY NO. 212 10 6836</p>		<p>17. INFORMANT ADDRESS 36 HOSPITAL RECORDS-ST. AGNES HOSPITAL</p>	
<p>18. 603 XI</p> <div style="display: flex; justify-content: space-between;"> <div> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>CAUSE OF DEATH (A) CHRONIC RENAL INSUFFICIENCY DUE TO (B) ACUTE PULMONARY EDEMA DUE TO (C) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH ?</p> </div> </div>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from AUGUST 8, 19 67 to AUGUST 10, 19 67, that (X) (we) last saw the deceased alive on AUGUST 10, 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.</p>					
<p>23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>				<p>23B. DATE SIGNED 8/11/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) RODOLFO REVILLA, M.D.</p>		<p>23D. ADDRESS ST. AGNES HOSPITAL</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>	<p>24B. DATE 8-14-67</p>	<p>24C. NAME OF CEMETERY or CREMATORY LOUDBON PARK CEMETERY</p>		<p>24D. LOCATION (City, town, or county) (State) BALTIMORE-MARYLAND.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967</p>	<p>25B. NAME OF REGISTRAR [Signature]</p>	<p>25C. FUNERAL DIRECTOR ADDRESS WALTERS FUNERAL HOME PRATT and STRICKER ST</p>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7741				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7741	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MC GRATH, PEARL CHARLOTTE		2. DATE AND HOUR OF DEATH AUGUST 9, 1967 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21228 B. COUNTY BALTO. Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVES. BALTIMORE, MD. 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 205 NEWBERG AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/7/90	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL SPARKS DEC'D				14. MOTHER'S MAIDEN NAME MARY JANE (SEWARD) SPARKS DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO none		16. SOCIAL SECURITY NO. 218 12 6141		17. INFORMANT ADDRESS HOSPITAL RECORDS- ST. AGNES HOSP.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Remote Myocardial Infarcted (B) Infarcted (C) Myocardial		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 6, 1967 to AUGUST 9, 1967 , that (X) (we) last saw the deceased alive on AUGUST 9, 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.							
23A. SIGNATURE L. Angor George						23B. DATE SIGNED 08/09/67	
23C. PHYSICIAN'S NAME (Type) GEORGE ANGOV, MD.				23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSP-CATON AND WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 12, 1967		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemt.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS STERLING FUNERAL ESTATE 736 Edm. Av. Catonsville 28, Md.			

1. 2000年12月1日，甲企业向乙企业销售一批商品，售价为10000元，增值税税额为1700元，该批商品的成本为6000元。乙企业于2001年1月15日收到该批商品。

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FUNERAL DIRECTOR: IMPORTANT

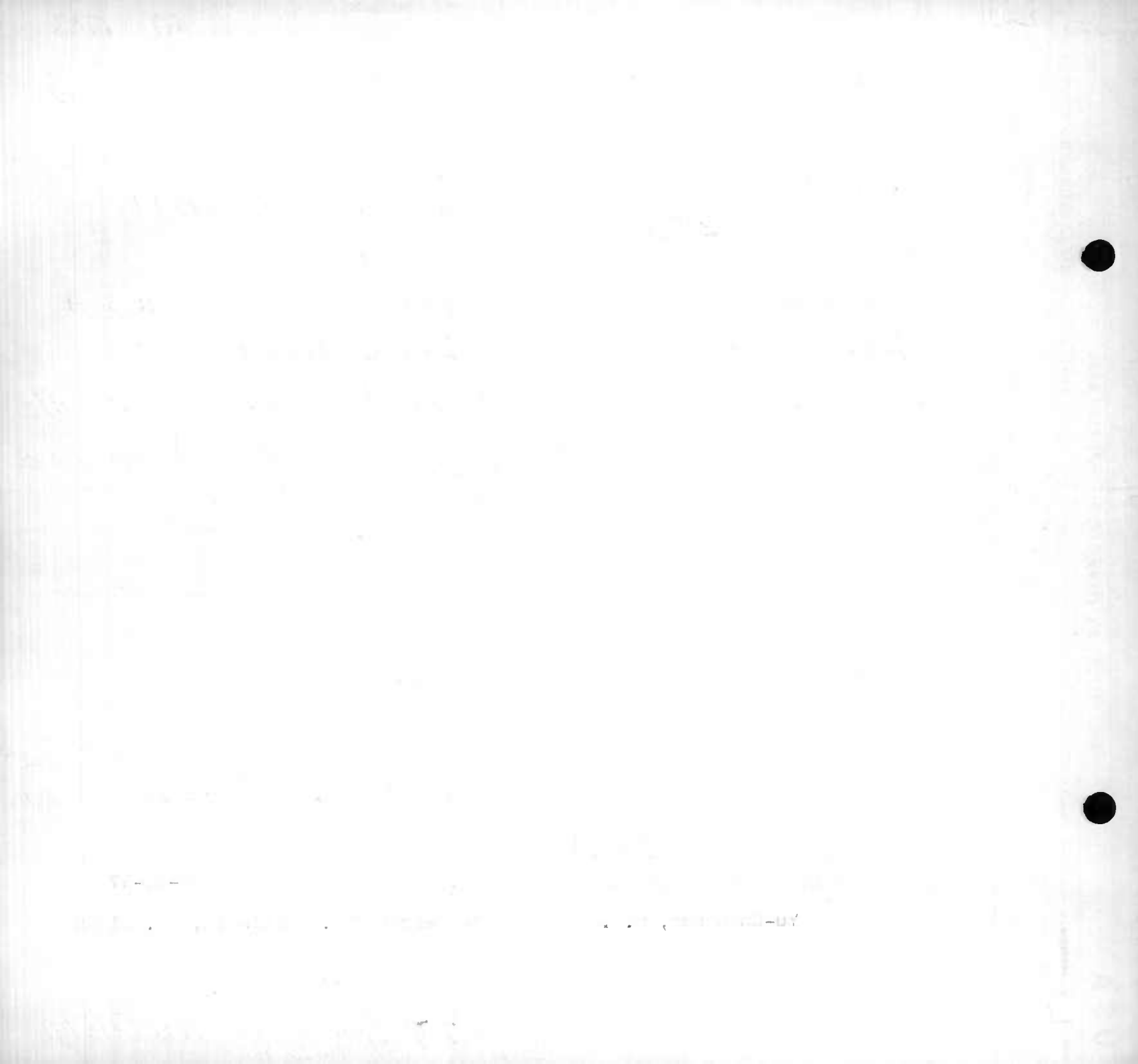
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7742				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7742	
1. NAME OF DECEASED (Type or Print) SARAH GROSSMAN				2. DATE AND HOUR OF DEATH 8-9-67 6:40 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH Charles General Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY MD			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-09			
				D. STREET ADDRESS (If rural, give location) 4019 Bonner Rd-16			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 2-18-92	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUMANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS COHEN				14. MOTHER'S MAIDEN NAME RIFKA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-28-8728		17. INFORMANT Chart Hosp		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CA of the cervix				CAUSE OF DEATH CA of the cervix		INTERVAL BETWEEN ONSET AND DEATH 7-24-67	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8-9-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-24 1967 to 8-9-67 19 67 that (I) (we) last saw the deceased alive on 8-9-67 6am and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Luis E Remy				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) MARION Friedman				23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY FARBAND		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7743
BIRTH NO. 67 7743		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 8/11/67 2:30 A.M.		
1. NAME OF DECEASED (Type or Print) Mary A. James				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13-08		
		D. STREET ADDRESS (If rural, give location) 1241 W. 37th St. 21211		
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2/24/01
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Spinner - Cotton Mill		9. AGE (In years last birthday) 66
13. FATHER'S NAME John Ambrose		14. MOTHER'S MAIDEN NAME Laura Tracy		12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 017690		17. INFORMANT ADDRESS John E. James 1241 W 37th St Balto
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 023X1		CAUSE OF DEATH ① Severe aortic insufficiency (Aortic) ② Severe coronary insufficiency		INTERVAL BETWEEN ONSET AND DEATH 30 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ↓ (numerous admissions to the Univ. Hospital)
22. I certify that (I) (this hospital) attended the deceased from 1961 to 7-16 19 67 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.				
23A. SIGNATURE Yu-Chen Lee		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-11-67
23C. PHYSICIAN'S NAME (Typed) Yu-Chen Lee, M.D.		23D. ADDRESS 34 Delrey AVE. Baltimore, Md. 21228		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-67		24C. NAME OF CEMETERY or CREMATORY Poplar Grove Cem
24D. LOCATION (City, town, or county) Cockeysville B21to Co		(State)		
25A. DATE RECEIVED BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR ADDRESS Burgess Funeral Home 3631 Falls Rd By Michael D. Dwyer Jr



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 67 7744		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7744	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) WATSON JOSEPH LUGENBEEL		
2. DATE AND HOUR OF DEATH 8-10-67 12:55 P.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY			5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.		
6. STREET ADDRESS (If rural, give location) 5609 MATTFELDT AVE.			7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-11-06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY B&O. R.R.		11. BIRTHPLACE (State or foreign country) md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY LUGENBEEL		14. MOTHER'S MAIDEN NAME EFFIE BEACH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No UNKNOWN		16. SOCIAL SECURITY NO. 705 05 7988		17. INFORMANT (Write) DORA MAY Lugenbeel ADDRESS AS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute myocardial infarction (B) arteriosclerotic cardiovascular disease (C) hypertensive cardiovascular disease (D) myocardial infarction W.K.W.		INTERVAL BETWEEN ONSET AND DEATH 9 yrs. 20 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-15 19 67 to 8-10 19 67 , that (I) (we) last saw the deceased alive on 8-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank Palmisano M.D.				23B. DATE SIGNED 8-10-67	
23C. PHYSICIAN'S NAME (Type) DR. FRANK PALMISANO M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 8-14-67		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem	
24D. LOCATION (City, town, or county) Pikesville, Balto Co Md		24E. LOCATION (State) Md		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Burgess Funeral Home		25D. ADDRESS 3631 Falls Rd	

WATSON JOHN LAMBERT

8-10-07

14.22

MD

PAID

UNION MEMORIAL HOSP.

2009 MATTHEW HVC.

W married

9-11-06 CO

CLERK GAO. K.R.

MD.

HARRY LAMBERT

EFFIE BEACH

(W/P)

UNKNOWN DORA MAY LAMBERT

UNKNOWN

Orthodontic Center

Department of Orthodontics

Department of Orthodontics

Yes

8-10

7-12

8-10

8-10

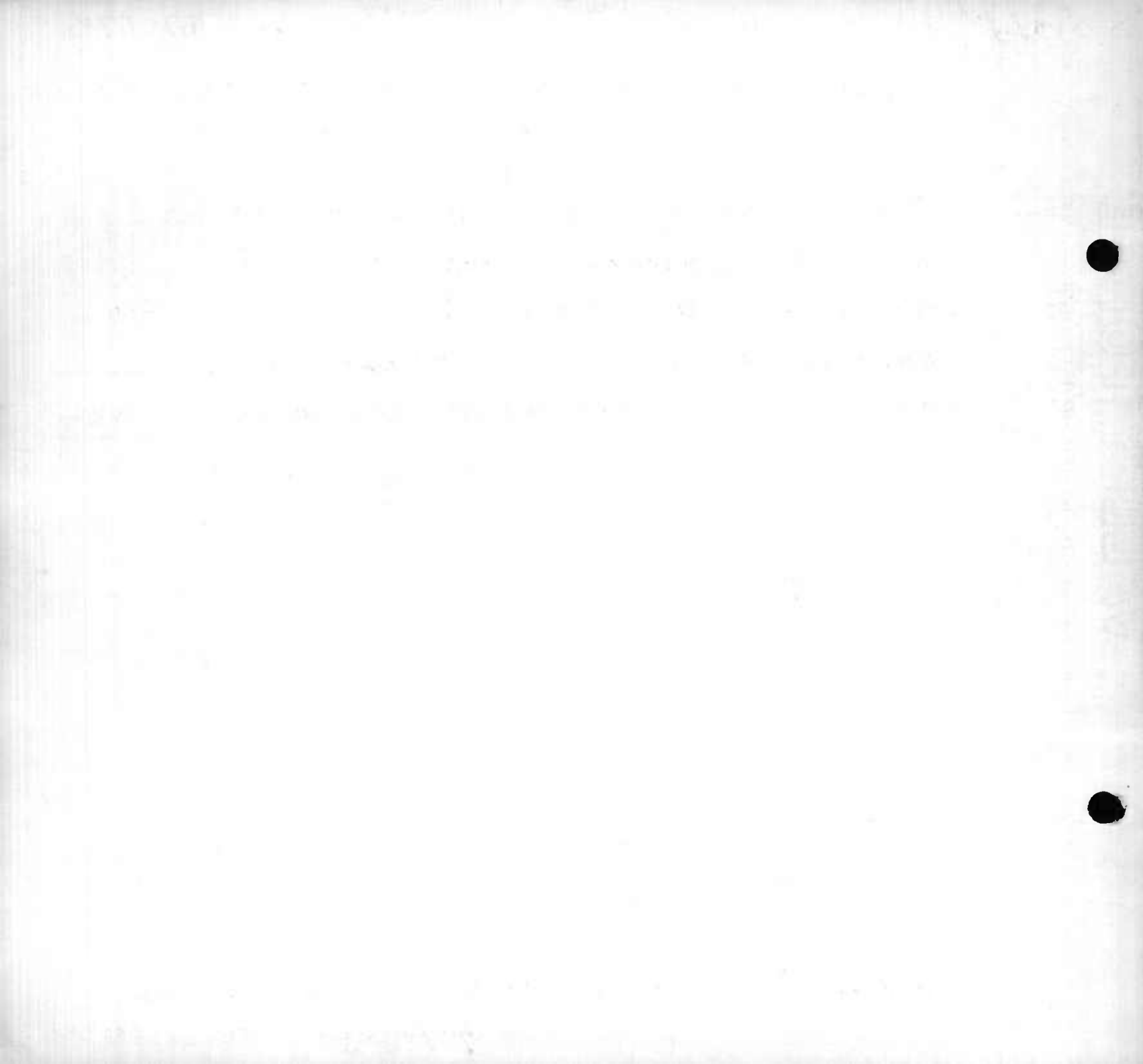
8-10-07

Frank Robinson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7745		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7745	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RICHMOND H. SNYDER		2. DATE AND HOUR OF DEATH AUG 6 1967 7:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO Co.		5. CITY OR TOWN (If outside city limits, write RURAL and give township) CHASE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTO. CITY HOSPITALS		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) ROUTE 14 BOX 26	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAR 10, 1909	9. AGE (in years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL		10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) N. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RICHMOND B. SNYDER		14. MOTHER'S MAIDEN NAME AGNES FOX	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 237-03-5453		17. INFORMANT RACIAEL SNYDER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.11		CAUSE OF DEATH (A) DUE TO Myocardial Infarction Immediate (B) DUE TO Atherosclerotic Cardiovascular Disease Ten years. (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 1957 to Aug 6 1967, that (I) (we) lost saw the deceased alive on Aug 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. B. Little M.D.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/67		24C. NAME OF CEMETERY or CREMATORY BEL AIR GARDENS	
24D. LOCATION (City, town, or county) (State) BALTO MD		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR J. J. Connelly Sons		ADDRESS 300 MACE	



C-642

67 7746

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 7746

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN EARL CARLISLE

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1967 6:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

18-03

39 and 41 S Stockton St. D.O.A.

D. STREET ADDRESS (If rural, give location)

39-41 South STOCKTON ST.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

JULY 17-1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UPHOLSTER

10B. KIND OF BUSINESS OR INDUSTRY

FURNITURE

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CARLISLE

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

237-10-9900

17. INFORMANT

ADDRESS

ALMA HEBLER 324 S. CALHOUN ST.

18.

416 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Rheumatic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

August 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-11-67

23C. NAME of CEMETERY or CREMATORY

GLEN HAVEN CEMETERY GOV. RITCHIE HWY. ANNE ARUNDEL CO.

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

24B. NAME OF REGISTRAR

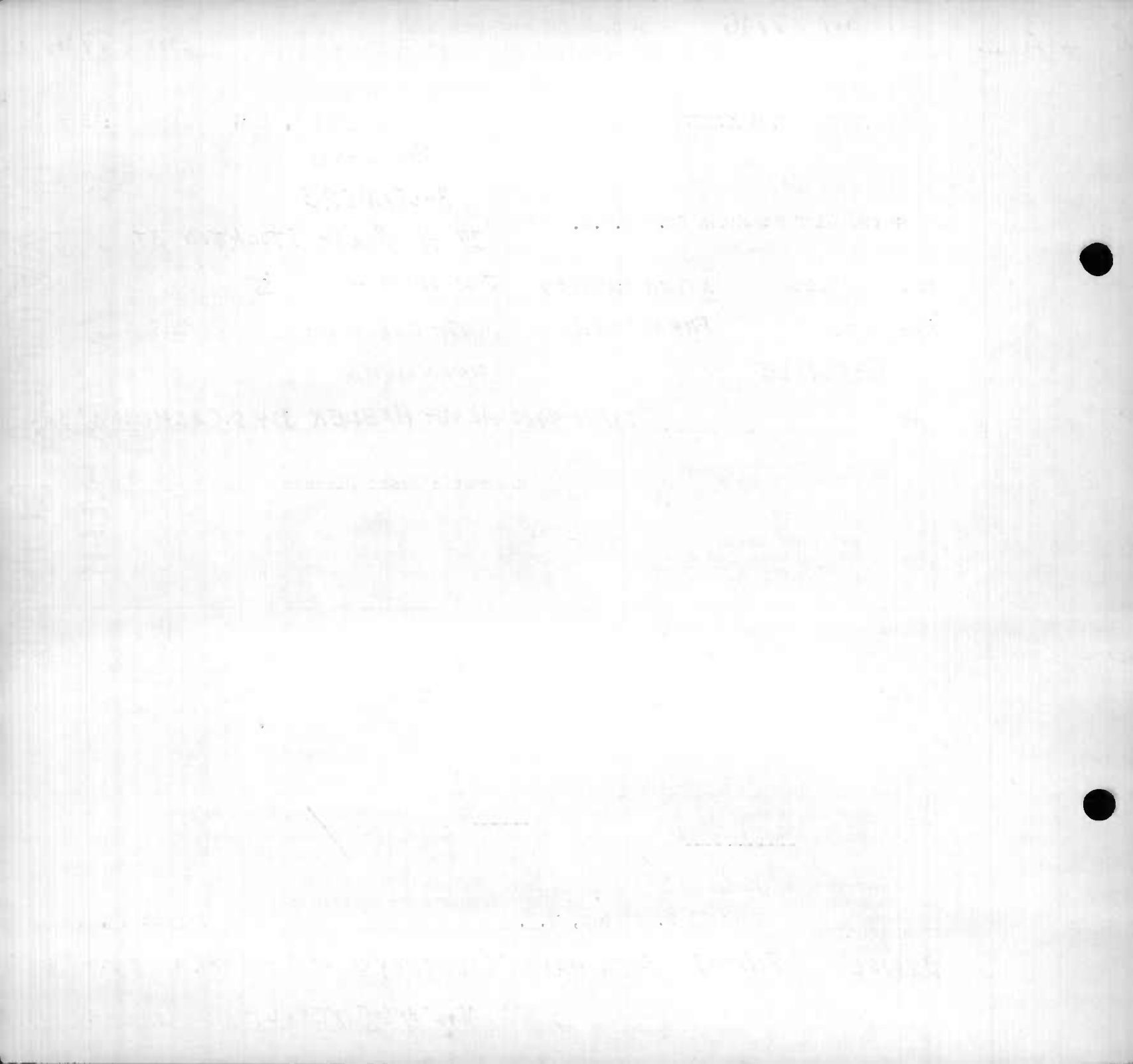
Robert E. Fisher

24C. FUNERAL DIRECTOR

WALTERS FUNERAL HOME

ADDRESS

PRATT + STRICKER STS.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-15264 67 7747				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7747	
1. NAME OF DECEASED (Type or Print) Victor Cantalupo				2. DATE AND HOUR OF DEATH Aug 9 1967 11 45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
				D. STREET ADDRESS (If rural, give location) 3721 Faith Ave. #24.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8/1/67	9. AGE (In years last birthday) 8	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Leo J. Cantalupo				14. MOTHER'S MAIDEN NAME Elaine Repp.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. —		17. INFORMANT Hosp. chart.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 754.51 CAUSE OF DEATH (A) Cong. heart failure (B) Congenital heart disease (C) — INTERVAL BETWEEN ONSET AND DEATH 2 8							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPRDX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 5 1967 to Aug 9 1967, that (I) (we) last saw the deceased alive on Aug 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Franklin L. Johnson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) Franklin L. Johnson				23D. ADDRESS University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-67		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.		24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD, BALTO, CO, MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Charles J. Deiler		ADDRESS 901 S. CONKLING ST. BALTO, 21224, MD.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7748		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7748	
M.E. CASE NO.		WALTER LAMKA		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		WALTER J. LAMKA		2. DATE AND HOUR OF DEATH 9 AUGUST 1967 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		ESSEX		53-00	
D. STREET ADDRESS (If rural, give location)		506 S. MARLYN AVENUE - 21221			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/30/92	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER		MEAT PACKER		MARYLAND	
13. FATHER'S NAME JAKE		14. MOTHER'S MAIDEN NAME ELNORA DELINSKI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 213-10-3501		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) BRONCHO PNEUMONIA DUE TO		95 days	
		(B) ASPIRATION of GASTRIC SECRETIONS 5ds. DUE TO			
		(C) CEREBRAL VASCULAR ACCIDENT DUE TO		10 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/24/19 67 to 8/9/19 67, that (I) last saw the deceased alive on 9 AUGUST 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Russell D. Hicks		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 AUGUST 1967	
23C. PHYSICIAN'S NAME (Type) RUSSELL D. HICKS		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE MD 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/12/67		24C. NAME OF CEMETERY or CREMATORY SACRED HEART	
24D. LOCATION (City, town, or county) (State) BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR J. G. CONAGELLY SONS	
				ADDRESS 300 WACE	

Genetic and clinical

History of genetic studies

Genetic variation in man

9 hours 12 51

History of genetics

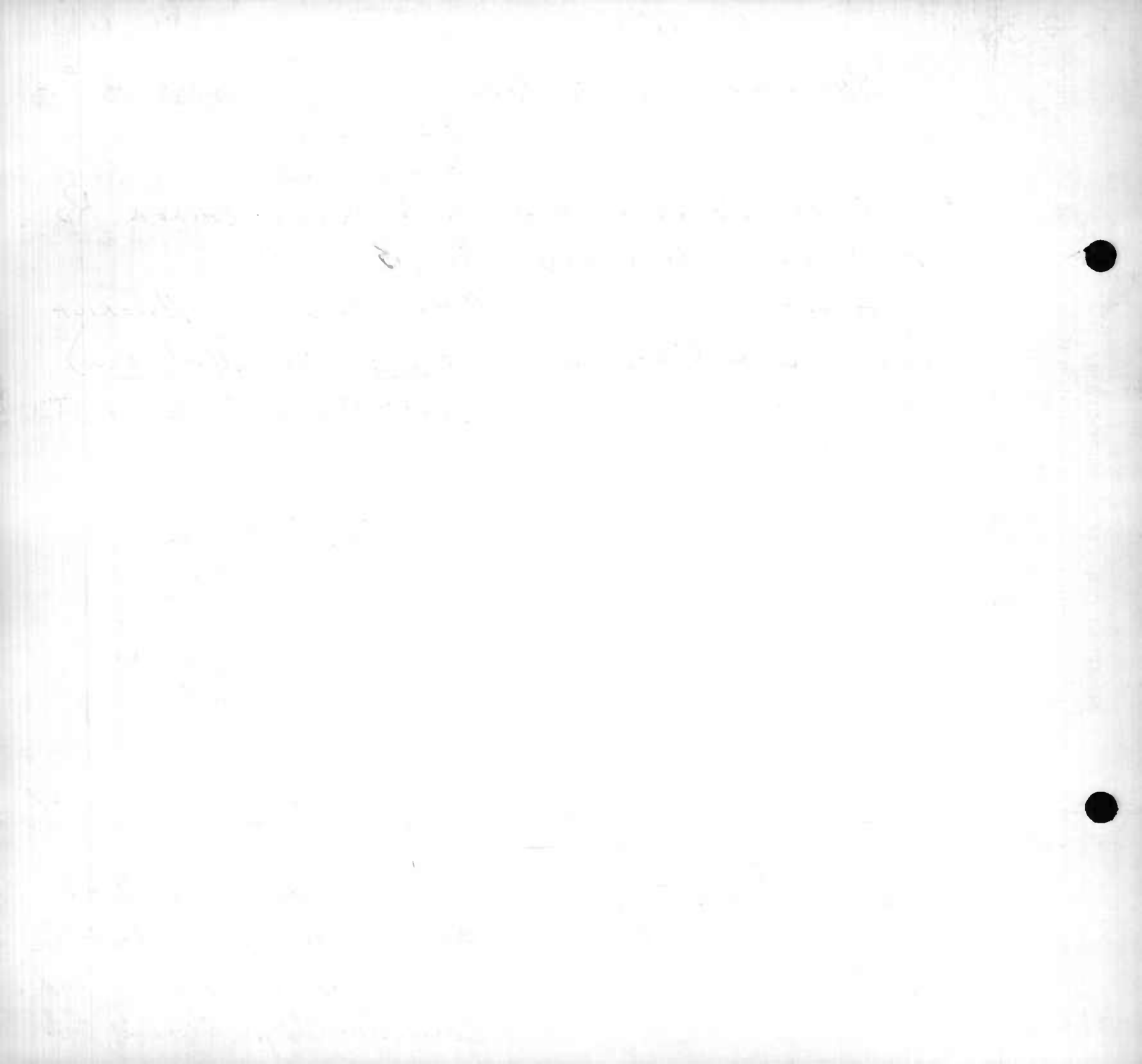
Genetic variation

9 hours 12 51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

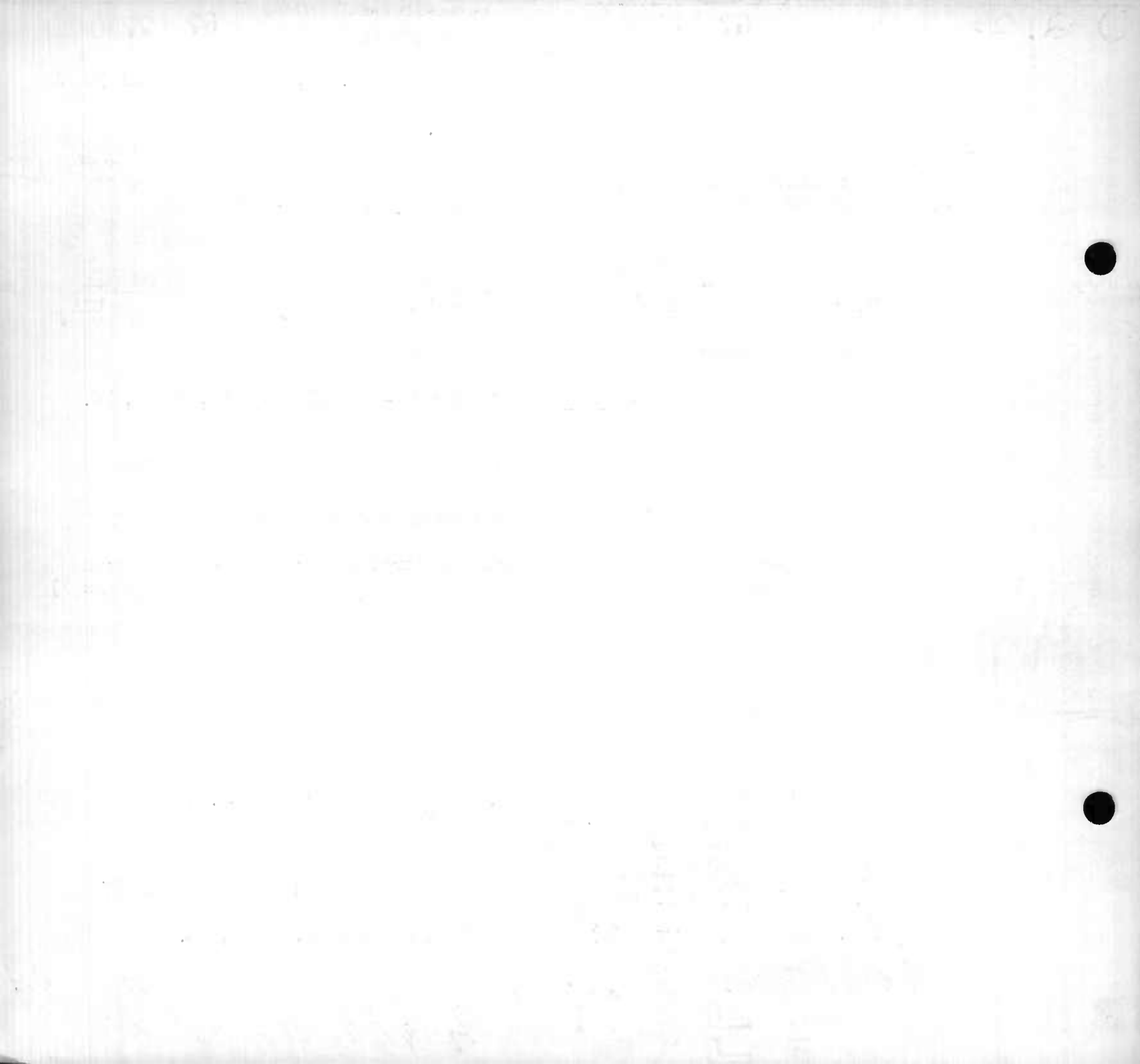
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7749	
67 7749				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RAGSDALE DOROTHY KATHERINE	
2. DATE AND HOUR OF DEATH August 9, 1967 10 50 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balls Co		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		8. DATE OF BIRTH 8/4/17 9. AGE (In years last birthday) 54			
D. STREET ADDRESS (If rural, give location) 1636 RICKENBACKER RD		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF			
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME LINWOOD L. CRIDLIN		14. MOTHER'S MAIDEN NAME ANNA K. (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-03-1010		17. INFORMANT ADDRESS Joyce F. Williams - 1 Boyer Ct.	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) Encephalomalacia of left cerebello-pontile area DUE TO (C) W.K.W.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/19 1967 to 8/9 1967 , that (I) was last saw the deceased alive on 8/9 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE W.H. Oehlert				23B. DATE SIGNED 8/9/67	
23C. PHYSICIAN'S NAME (Type) W.H. Oehlert				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/10/67		24C. NAME OF CEMETERY or CREMATORY Landon Pk.	
24D. LOCATION (City, town or county) (State) Fred. Rd. Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS John J. Connelly Jr. Essex 21, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7750					Registered No. 67 7750				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Minnie Frances Jacobs					2. DATE AND HOUR OF DEATH Aug. 10, 1967 11: 30 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive					A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1520 S. Hanover Street				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 1/8/05	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messman		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Perrica					14. MOTHER'S MAIDEN NAME Constance Di Blasi				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-8985		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ventricular fibrillation					INTERVAL BETWEEN ONSET AND DEATH Hour				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Probable myocardial infarction					1 day ?				
Arteriosclerotic heart disease					Unknown (6 mos ?)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Aug. 9 1967 to Aug. 10 1967, that (I) (we) last saw the deceased alive on Aug. 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John A. Kibelstis								23B. DATE SIGNED 8/10/67	
23C. PHYSICIAN'S NAME (Type) John A. Kibelstis, Surgeon (R)								23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/14/67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill			24D. LOCATION (City, town, or county) (State) Glen Burnie Md. AA		
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			25B. NAME OF REGISTRAR Robert E. [unclear]			25C. FUNERAL DIRECTOR [unclear]			25D. ADDRESS 130 E. Fort Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7751	
BIRTH NO. 67 7751		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMAS, MARY ELIZABETH		2. DATE AND HOUR OF DEATH 8/6/67 12:41 N.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
MARYLAND GEN'L HOSP FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE MARYLAND 48		Md. ANNE ARUNDEL Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERN MARYLAND D. STREET ADDRESS (If rural, give location) Box #151 Rt #1 52-00			
5. SEX F	6. RACE Cane	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 09-21-18	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY FACTORY WORKER PLASTICS PLANT CUMBERLAND, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS LANG		14. MOTHER'S MAIDEN NAME HATTIE WELSH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-12-2555		17. INFORMANT Waley A. Thomas same as #4 above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Pneumonia -		10 days	
ANTECEDENT CAUSES		(B) Carcinoma of esophagus -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) c erosion into trachea			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION MARCH 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED COLON TRANSPLANT. CA ESOPHAGUS		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-18-67 19 to 8-7-67 19, that (I) (we) last saw the deceased alive on 8-7-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Beasley M.D.				23B. DATE SIGNED 8/7/67	
23C. PHYSICIAN'S NAME (Type) ROBERT M. BEASLEY M.D.				23D. ADDRESS MARYLAND GEN'L HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/67		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) Glen Burnie		24E. ADDRESS (State) A.A. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 14 1967		R. E. E. F. F. F.		Hopping Funeral Home - Annapolis, Md.	

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211 212 213 214 215 216 217 218 219 220

FUNERAL DIRECTOR: IMPORTANT

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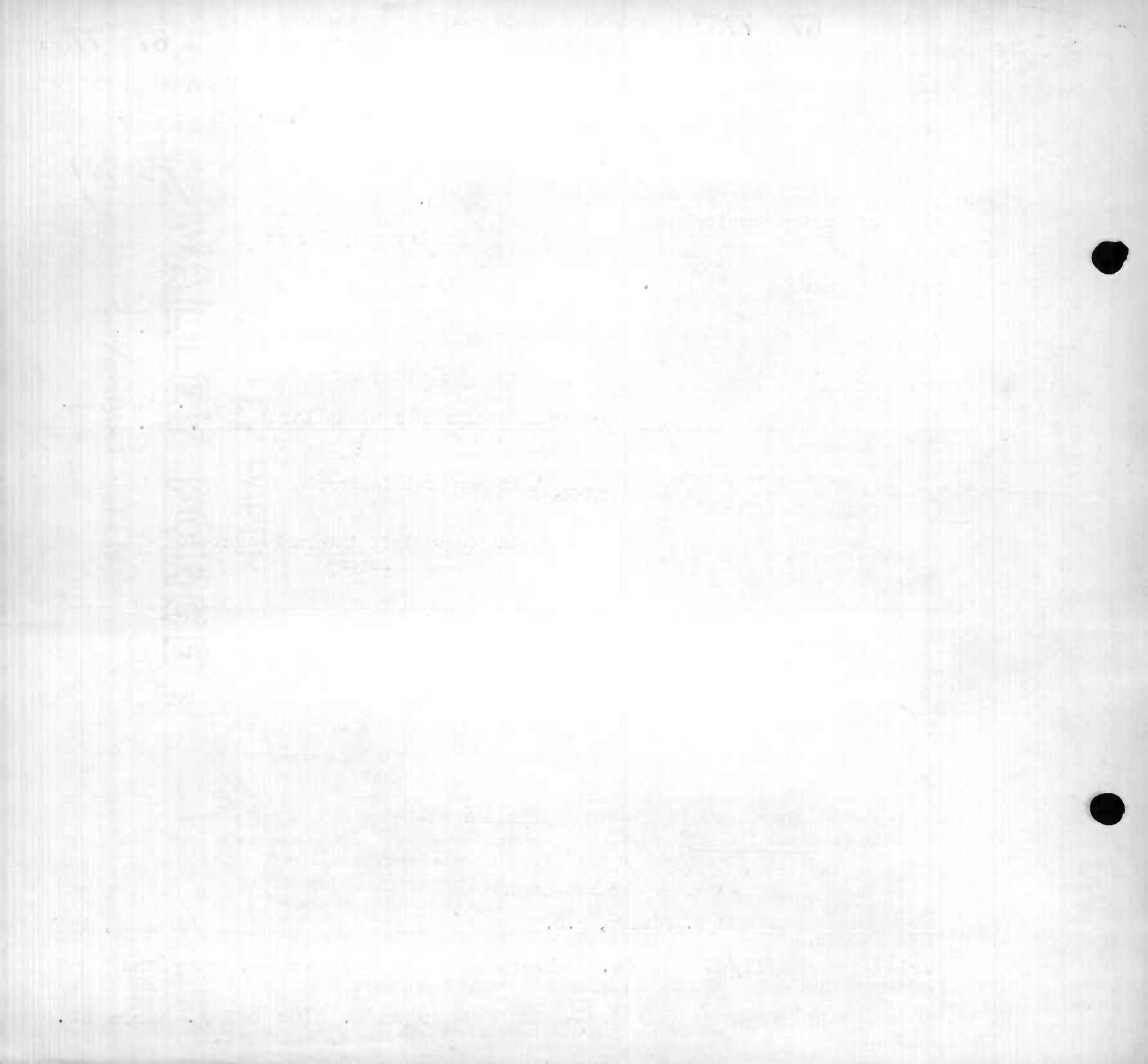
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7752	
BIRTH NO. 67 7752				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>WILHELM L'Allemand</u>			2. DATE AND HOUR OF DEATH <u>8-9-67</u> <u>6 30</u> A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Melchor Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>14-01</u> D. STREET ADDRESS (If rural, give location) <u>1419 Mt Royal Ave</u>		
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify)	8. DATE OF BIRTH <u>4-4-1871</u>	9. AGE (In years last birthday) <u>96</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles L'Allemand</u>			14. MOTHER'S MAIDEN NAME <u>Emele Ruehle</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Louise H. L' Allemand 3603 Yolando Rd.</u>
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>arteriosclerotic Heart Disease</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>65</u> to <u>August 9</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>August 9</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Z. Feenberg</u>				23B. DATE SIGNED <u>8/11/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY Z. Feenberg</u>				23D. ADDRESS M.D. <u>1101 E. Baltimore St. Baltimore, Maryland 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-12-1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Western</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1967</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u>		25D. ADDRESS <u>3201 W. NORTH AVE</u>	

C-534

67 7753 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7753

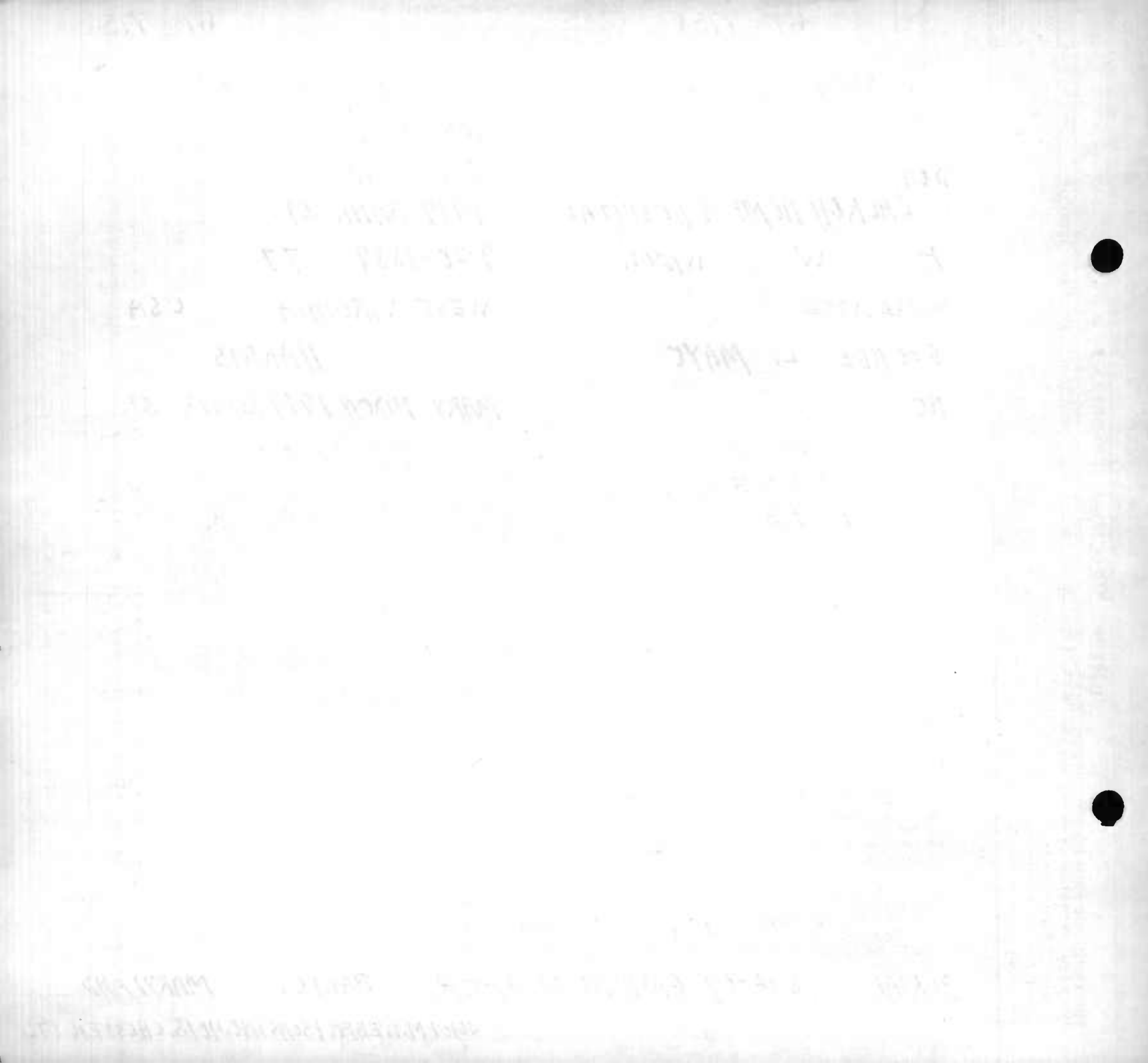
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) AMBROSE CHANDLER		2. DATE AND HOUR PRONOUNCED DEAD August 8, 1967 9:50 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 905 Burgundy Street	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 9/22/10
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Chandler		14. MOTHER'S MAIDEN NAME Martha Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 250-03-1179	17. INFORMANT ADDRESS 1232 S. 23rd St. Lucille Chandler, Phil. PA.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Left cerebral infarction Occlusion of left internal carotid artery ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED August 9, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 8/14/67	23C. NAME OF CEMETERY or CREMATORY Mt. Calvary	23D. LOCATION (City, town, or county) (State) Baltimore, Maryland
24A. DATE REC'D BY HEALTH DEPT. AUG 14 1967	24B. NAME OF REGISTRAR Robert E. Fisher, M.D.	24C. FUNERAL DIRECTOR Charles A. Rice	ADDRESS 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7754		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7754	
1. NAME OF DECEASED (Type or Print) ALTA R. WRIGHT			2. DATE AND HOUR OF DEATH AUG. 12 - 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. CHURCH HOME & HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1919 BANK ST.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9-20-1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GEORGE L. MAYO			14. MOTHER'S MAIDEN NAME HARRIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARY NIXON 1919 BANK ST.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1			CAUSE OF DEATH (A) DUE TO Hypertension (CVD) (B) DUE TO Complete Heart Block (C) 3 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Generalized ASCVD			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 5-65 19 to 8-11-67 19, that (I) (we) last saw the deceased alive on 8-11-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore T. Niznik M.D.				23B. DATE SIGNED 8-14-67	
23C. PHYSICIAN'S NAME (Type) Theodore T. NIZNIK				23D. ADDRESS 21231 429 S. Chester St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-16-67		24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH	
24D. LOCATION (City, town, or county) (State) BALTO, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967			
25B. NAME OF REGISTRAR John M. Weber		25C. FUNERAL DIRECTOR ADDRESS JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.			



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67 7755

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7755

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID

LIDE

2. DATE AND HOUR PRONOUNCED DEAD

August 10, 1967

7:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2744 Riggs Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7-2-1907

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

O. MATHESION CHEM. DARLINGTON, S.C.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

ROBERT LIDE

14. MOTHER'S MAIDEN NAME

LOUISE LIDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Annie Lide 2744 Riggs Avenue

18. E904.9

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Cranio-Cerebral Injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subj. fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-15-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

Arbutus,

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 14 1967

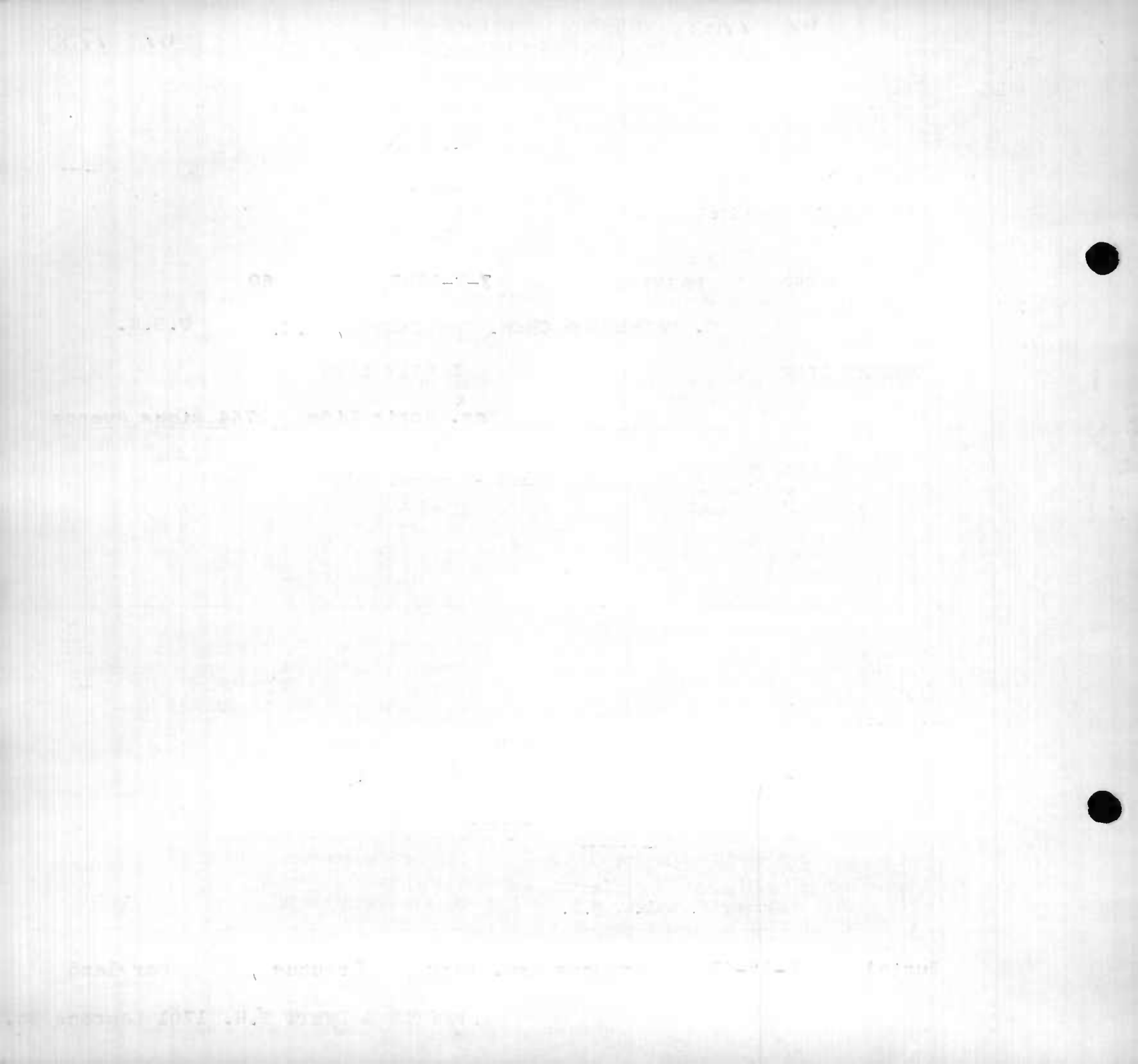
24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

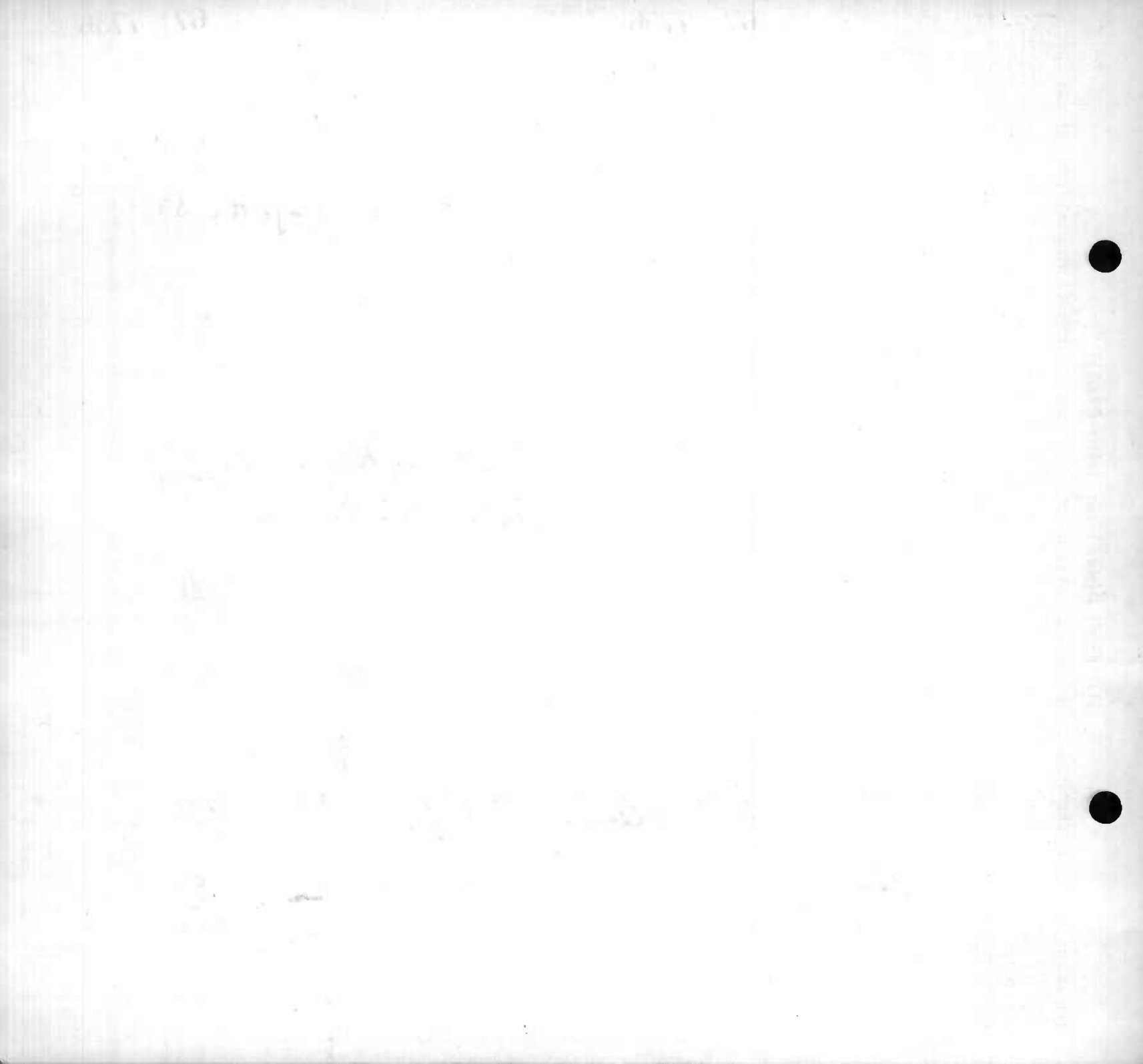
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

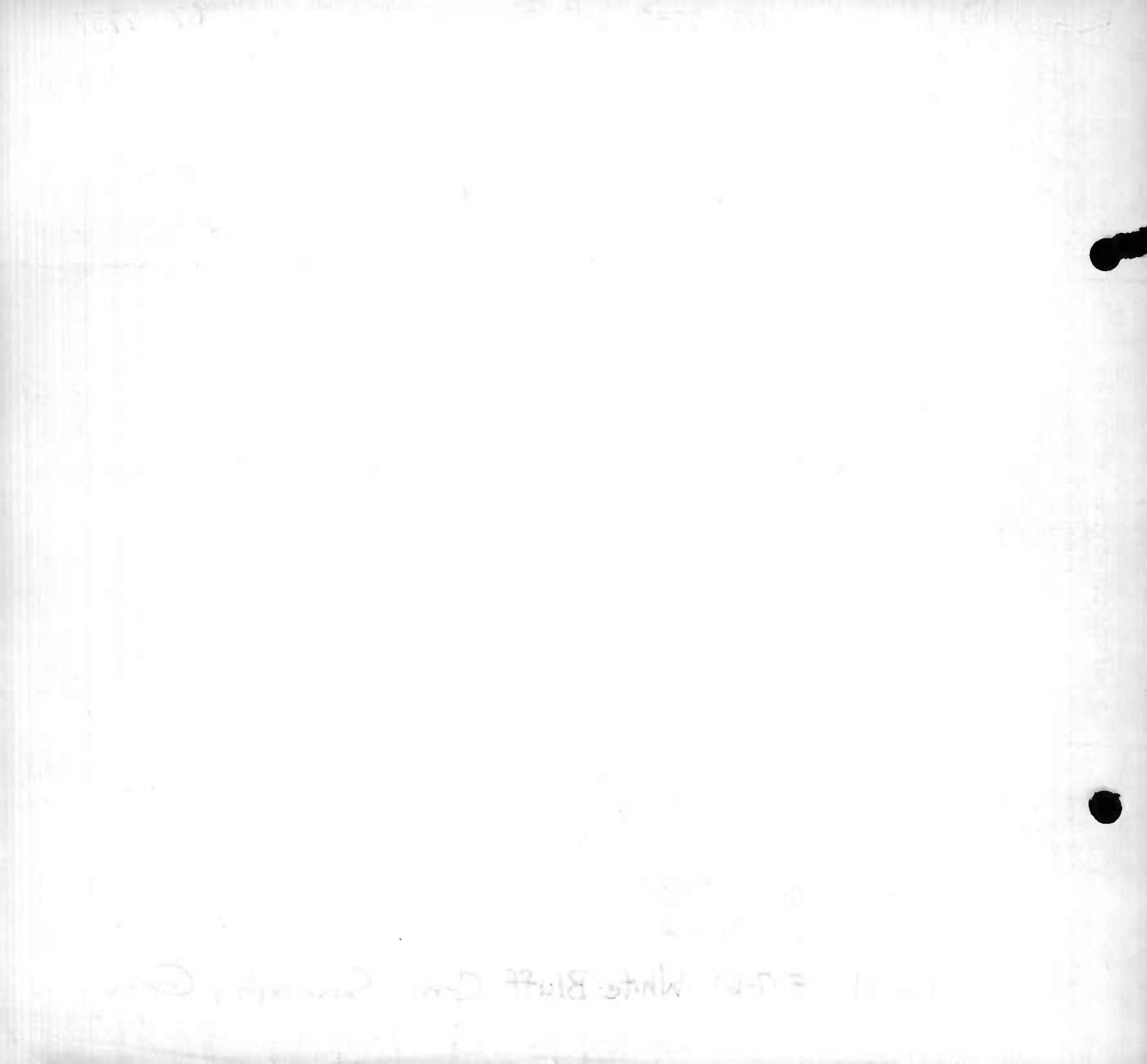
BIRTH NO. 67 7756		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7756	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>ELLA SMALL</i>		2. DATE AND HOUR OF DEATH <i>Aug. 12th 1967 12 A.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00719 W. Fayette St.</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>719 W. Fayette St.</i>	
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>June 1, 18</i>	9. AGE (in years lost birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Georgetown S.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wick Wallace</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Johnson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>331 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral hemorrhage</i> DUE TO (B) <i>Arterio sclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>2</i> <i>1</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 10</i> 1967 to <i>Aug 11</i> 1967, that (I) (we) last saw the deceased alive on <i>Aug 11</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harry Glassman</i>				23B. DATE SIGNED <i>Aug 13 - 67</i>	
23C. PHYSICIAN'S NAME (Type) <i>HARRY GLASSMAN M.D.</i>				23D. ADDRESS <i>712 W. Fayette St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-16-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Georgetown</i>	
24D. LOCATION (City, town, or county) (State) <i>Se. Caroline</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 14 1967</i>		25B. NAME OF REGISTRAR <i>R. B. E. Johnson</i>	
25C. FUNERAL DIRECTOR ADDRESS <i>Georgetown Funeral Home Georgetown, S.C.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7757 CERTIFICATE OF DEATH					Registered No. 67 7757				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Christopher Louis Kenon					2. DATE AND HOUR OF DEATH Aug 11 1967 10:15 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (When deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Public Health Service Hospital Wyman Pl. Dr. + 31 St. St.					A. STATE Ga. B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Savannah				
					D. STREET ADDRESS (If rural, give location) 207 Holland Rd				
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 7/26/47	9. AGE (In years last birthday) 20	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fla.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Horace Kenon				14. MOTHER'S MAIDEN NAME Maggie Owens					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unk no				16. SOCIAL SECURITY NO. 252 742187		17. INFORMANT ADDRESS Records. USPHS Harp Balto Md			
18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Acute Myelogenous leukemia DUE TO (B) _____ DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH months				
18. II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) no					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from Aug 1 1967 to Aug 11 1967 , that (I) (we) last saw the deceased alive on Aug 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE J. Douglas Morris					23B. DATE SIGNED 8/11/67				
23C. PHYSICIAN'S NAME (Type) J. Douglas Morris					23D. ADDRESS USPHS Harp Balto Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-67		24C. NAME OF CEMETERY or CREMATORY White Bluff Cem.			24D. LOCATION (City, town, or county) (State) Savannah, Georgia		
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Terrell Nelson			ADDRESS 1348 N. Gallatin St		



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67 7758

BALTIMORE CITY HEALTH DEPARTMENT

67 7758

BIRTH NO. 67-06336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) VERNELL THOMPSON		2. DATE AND HOUR PRONOUNCED DEAD August 10, 1967 8:50 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2128 Callow Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2128 Callow Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3-31-67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 4
13. FATHER'S NAME Vernell Coleman		14. MOTHER'S MAIDEN NAME Yvonne Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	17. INFORMANT Margaret Thompson
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS (SDII)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED August 10, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-13-67	23C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.
24A. DATE REC'D BY HEALTH DEPT. AUG 14 1967		24B. NAME OF REGISTRAR R. E. Taylor	24C. FUNERAL DIRECTOR Kelson Funeral Home
24D. LOCATION (City, town, or county) (State) Ba. Ho., Md.		ADDRESS 1348 Calhoun St.	

Vernell Coleman

Yvonne Thompson

Harold Thompson

APR 1967

10000

10000

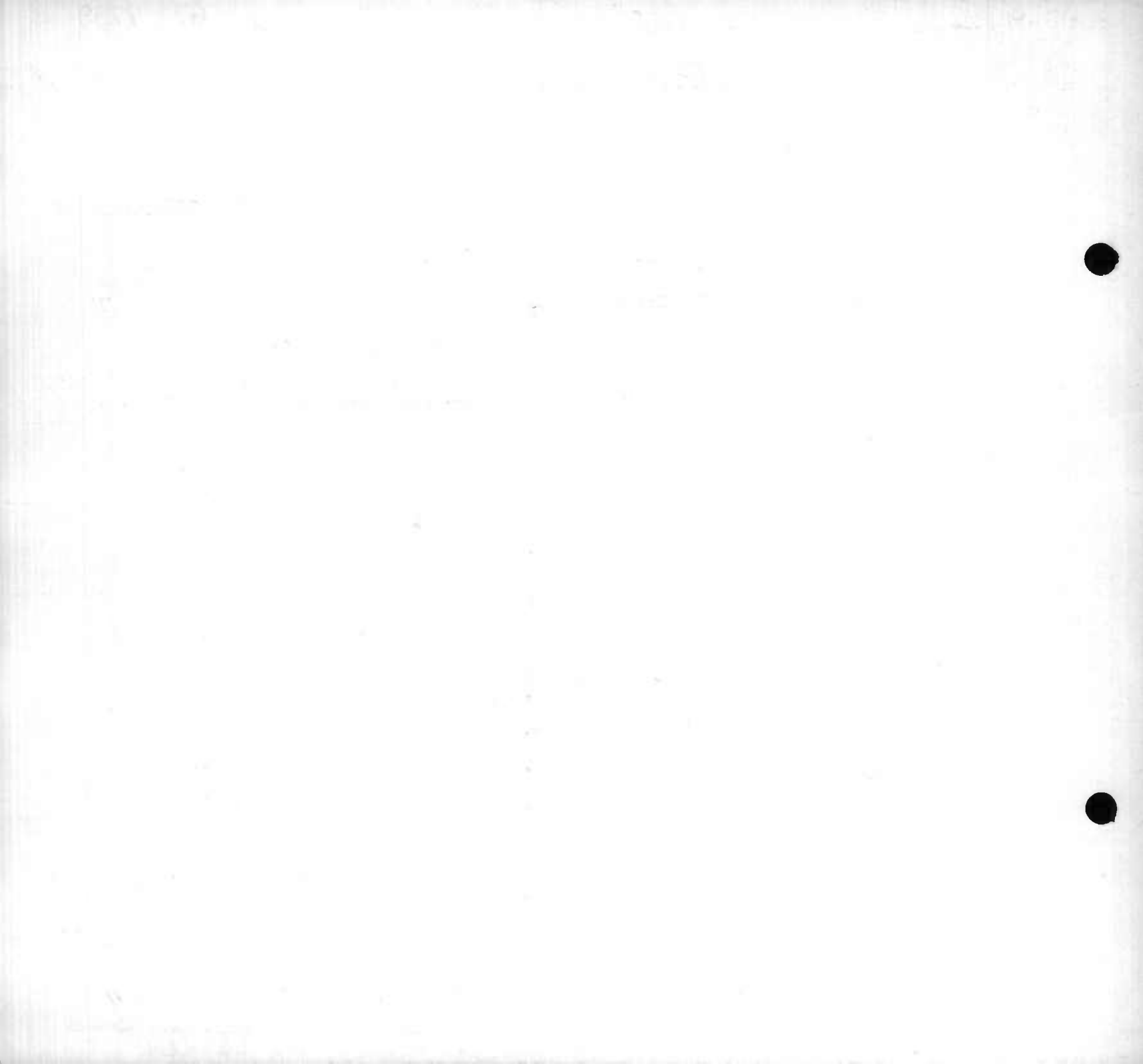
Special 8-13-67 Mt Auburn Cem. Boston, MA

Kelvin Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

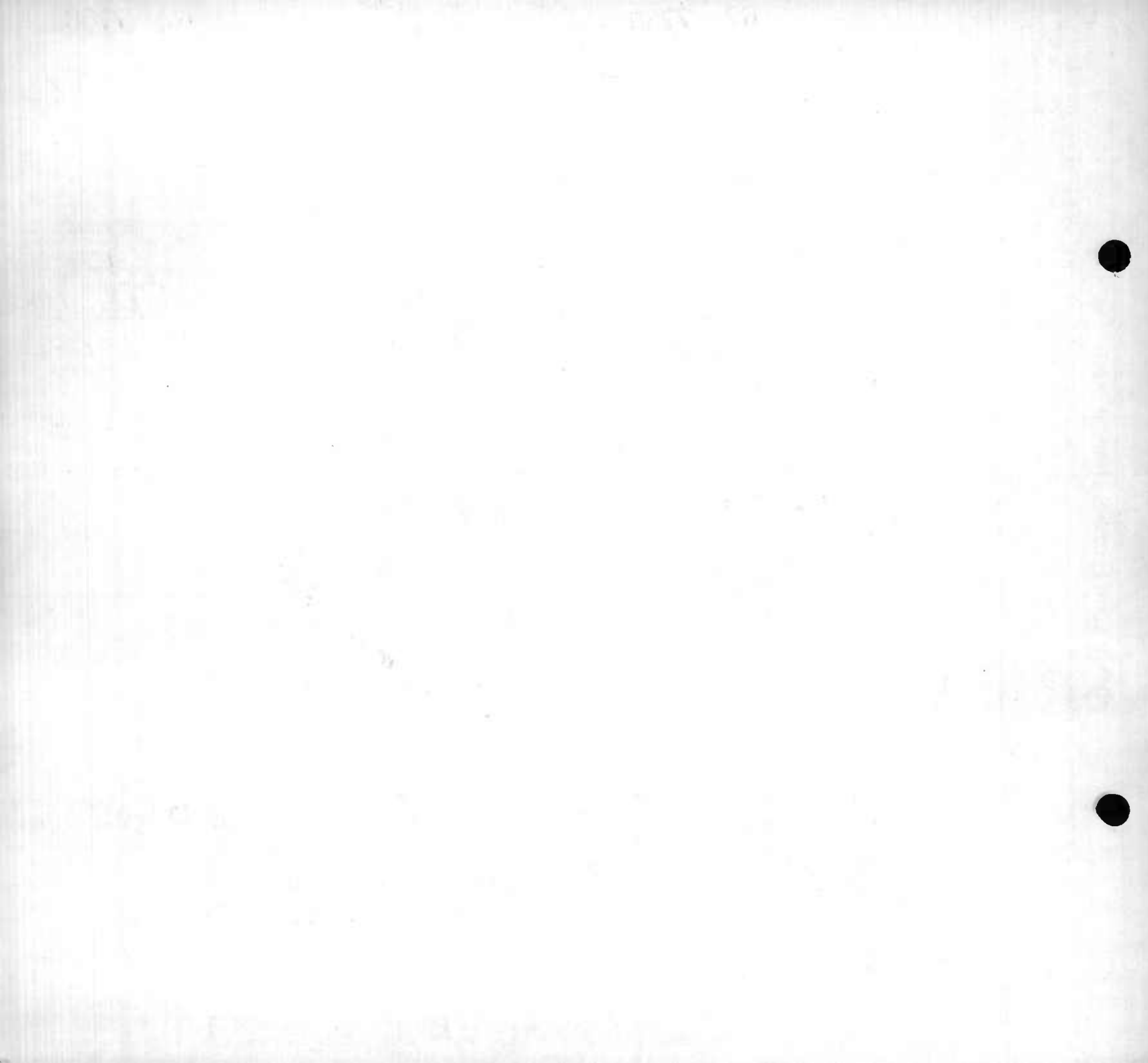
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7759	
BIRTH NO. 67 7759		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>HELEN G. Gugliuzza</i>		2. DATE AND HOUR OF DEATH <i>8-10-67 4:55 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21228</i>			
		D. STREET ADDRESS (If rural, give location) <i>328 Whitfield Rd.</i>			
5. SEX <i>FE</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>6/29/02</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Md. Paper Box Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Thomas Geisenclaffer</i>		14. MOTHER'S MARDEN NAME <i>NORA Swartz</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-2546</i>		17. INFORMANT <i>Sam J. Gugliuzza</i> ADDRESS <i>21228 328 Whitfield Rd.</i>	
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pulm. Edema</i>		CAUSE OF DEATH (A) DUE TO <i>ASCVD</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		(B) DUE TO		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Bleeding duodenal ulcer</i>					
19A. DATE OF OPERATION <i>8-9-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding Duodenal ulcer</i>		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>August 4 1967</i> to <i>August 10 1967</i> , that (I) <u>(we)</u> last saw the deceased alive on <i>10 August 1967</i> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>8-10-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>KYE YOON KIY</i>				23D. ADDRESS <i>Bon Secours Hospital 2036 W. Fayette St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/12/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Harold Funeral Home</i>	
25D. ADDRESS <i>Harold</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67-15717 67 7760					CERTIFICATE OF DEATH				
Registered No. 67 7760					4				
M.E. CASE NO. GIRL									
1. NAME OF DECEASED (Type or Print) Baby of Vares, Margaret Janet					2. DATE AND HOUR OF DEATH 8-5-67 5:29 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL					A. STATE MARYLAND				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-05				
					D. STREET ADDRESS (If rural, give location) 628 UMBRA ST				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8-5-67	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? UNITED STATES	13. FATHER'S NAME JAMES P. VARES	14. MOTHER'S MAIDEN NAME MARGARET JANET ANNEFELSER
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. 762.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					1 hr 03 min				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4:26 AM 8-5-67 to 8-5-67 5:29 AM that (I) (we) lost saw the deceased alive on 8-5-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Honorio R. Ylizarde Jr. M.D.					23B. DATE SIGNED 8-5-67				
23C. PHYSICIAN'S NAME (Type) HONORIO R. YLIZARDE JR. M.D.					23D. ADDRESS FRANKLIN SQUARE HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Franklin Sq. Hos		24D. LOCATION (City, town, or county) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR ADDRESS 7 HOSPITAL DISPOSAL					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7761		CERTIFICATE OF DEATH		67 7761	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mrs Edith Leef		8-9-67 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
MARYLAND GENERAL HOSP		Md BALTO-C.			
48		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		REISTERSTOWN		53-00	
		D. STREET ADDRESS (If rural, give location)			
		55 HANOVER Rd			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	MARRIED	Jan. 23, 1886	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE		NONE		Baltimore City UNKNOWN	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Edward L. Scott		Emma Lantz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-09-9094		Sister in law same as dec.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 I		(A) CARDIAC SHOCK		4 hrs	
ANTECEDENT CAUSES		(B) MYOCARDIAL INFARCTION		1 day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Anemia		?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE				No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 8/9 to 8/9 1967, and that (1) (we) last saw the deceased alive on 8/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Frank J. Zorick				8/9/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANK J. ZORICK		Maryland Gen'l Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Aug. 12, 67	Pleasant Grove Cemetery	Owings Mills, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1967	Robert E. Johnson	J. F. Edine & Sons		Reisterstown, Md	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7762	
BIRTH NO.		67 7762		CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) EVELYN (Evelyn F. Andersavage) ANDERSA VAGE		2. DATE AND HOUR OF DEATH Aug 11, 1967 11:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-10 D. STREET ADDRESS (If rural, give location) 414 N. BOULDIN			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-17-'13	9. AGE (In years lost birthday) 5453	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S A
13. FATHER'S NAME HENRY WHITSEL (Weitzel)			14. MOTHER'S MAIDEN NAME BLANCHE TILLMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Mr. Frank B. Andersavage 414 N. Bouldin St. Balto. Md.	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) INTRACEREBRAL HEMORRHAGE DUE TO		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		18B. ARTERIOCLEROTIC HEART DISEASE DUE TO		YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-4 19 67 to 8-11 19 67 , that (I) (we) last saw the deceased alive on 8-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE VENERACION M.D.				23B. DATE SIGNED Aug 11, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS CHURCH HOME AND HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 15, 1967		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			
25B. NAME OF REGISTRAR R. O. R. E. F. D. M.		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave, Balto. Md.			

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JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

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U.S. AIR FORCE
HONOLULU, HAWAII

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U.S. AIR FORCE
HONOLULU, HAWAII

Aug 6th 1967 released and approved by Dr. PALOMINO

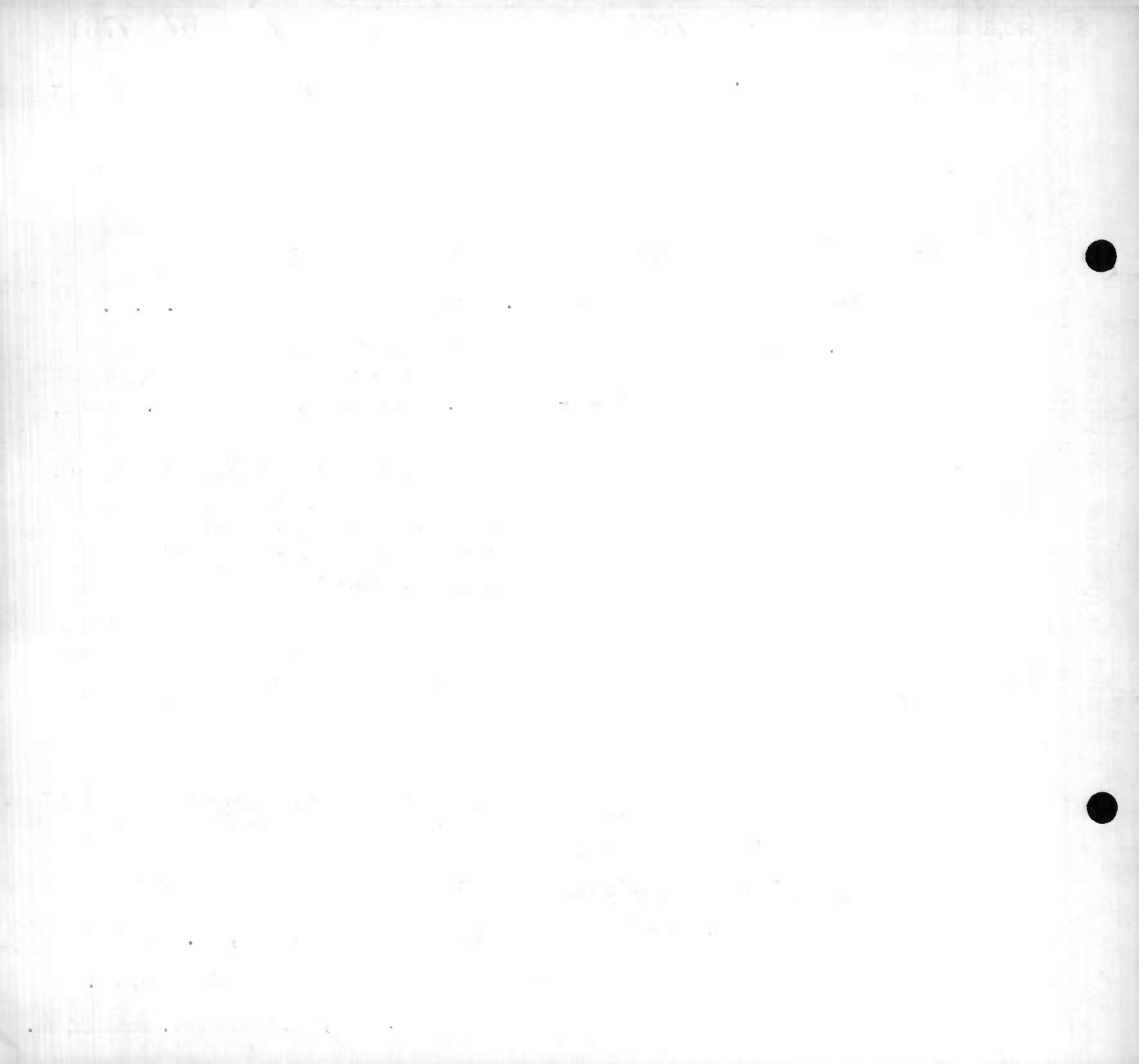
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-540		67 7763		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7763	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				8/5/67 7:25 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Union Memorial Hospital				Maryland Montgomery Co.			
44				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Bethesda			
				D. STREET ADDRESS (If rural, give location)			
				7914 Sleaford Road			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
F		C				7/4/83	
						9. AGE (In years last birthday)	
						84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				Massachusetts		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles S Penhallow				Mary Co F Fin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				None		Dr. Frank T Baranco	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				19. CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Bromelid Pneumonia			
20. ANTECEDENT CAUSES				arteriosclerotic Vascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Strokes			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Fracture left femur, spontaneous			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7-21-67				Pneumonia Fract Hip		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
				Mental Hospital		Sheppard Pratt Hospital	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
6 28 67 3PM				While At Work		PT Fall To Floor	
22. I certify that (I) (this hospital) attended the deceased from 8/25 1967 to 8/15 1967, that (I) (we) last saw the deceased alive on 8/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D.		23B. DATE SIGNED	
Charles H. Classen, Jr.						8/5/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CHARLES H. CLASSEN, JR.,				THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		8-7-67		Cedar Hill Crematory		Suitland, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS			
AUG 15 1967		Robert E. Fairman		Robert A. Pumphrey, Bethesda, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7764					X				
BIRTH NO.					Registered No. 67 7764				
1. NAME OF DECEASED (Type or Print) William C. Kenney					2. DATE AND HOUR OF DEATH August 9, 1967 10 4 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk D. STREET ADDRESS (If rural, give location) 1723 Rita Road				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/12/04	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Mill- Retired			10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William T. Kenney					14. MOTHER'S MAIDEN NAME Ida Mae Mitchell				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-07-8358		17. INFORMANT (Wife) ADDRESS Mrs. Alice Kenney, 1723 Rita Rd. Dundalk, Maryland				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH few minutes					19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease with history of heart failure & old myocardial infarct. Hypothyroidism				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 24 1962 to Aug. 9 1967 , that (I) (we) last saw the deceased alive on Aug. 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.									
23A. SIGNATURE Ataollah Golpira M.D.					23B. DATE SIGNED 8/9/67			23C. PHYSICIAN'S NAME (Type) Ataollah Golpira M.D.	
23D. ADDRESS 1942 Cedar Lane Dundalk, Md. 21222									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR R. B. E. Bailey, M.D.		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7765

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN

STACHOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1967

9:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home & Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2616 Fait Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Never Married

B. DATE OF BIRTH

1/9/05

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Charwoman

10B. KIND OF BUSINESS OR INDUSTRY

National Bank Bldg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Anton Stachowski

14. MOTHER'S MAIDEN NAME

Anna Studzinski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-30-6345

17. INFORMANT
Brother-in-lawADDRESS
Md. 21207

Joseph B. Dembeck, 7804 Selgrave Rd. Balto.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/14/67

23C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

John J. Duda, 2929 Hudson St. Balto. Md.

ADDRESS

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7766		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7766	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Bertha Zielinski			2. DATE AND HOUR OF DEATH 8/9/67 3:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines Belaire 5837 Belair Rd. Baltimore, Md. 21206			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1110 S. Bouldin St. 21224		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 26, 1889	9. AGE (In years last birthday) 77	10. CITIZEN OF WHAT COUNTRY? U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Poland		
13. FATHER'S NAME Joseph Buczkowski			14. MOTHER'S MAIDEN NAME Josephine ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-16-3054		
17. INFORMANT (Daughter) Balto. Md. 21224 Mrs. Marie Lorden, 1110 S. Bouldin St.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 334 X 260 X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) Reported Stroke (B) Generalized Arteriosclerosis (C) _____ INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/8/67 to 8/9/67, that (I) (we) last saw the deceased alive on 8/8/67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 8/9/67		
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley			23D. ADDRESS 4900 Belair Rd. Baltimore, Md. 21206		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/67		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 2829 Hudson St. Balto. Md.	

2/7/02

August 18th
Cousin's Collection

Debit note
for

8/1/02

8/18 8/1/02

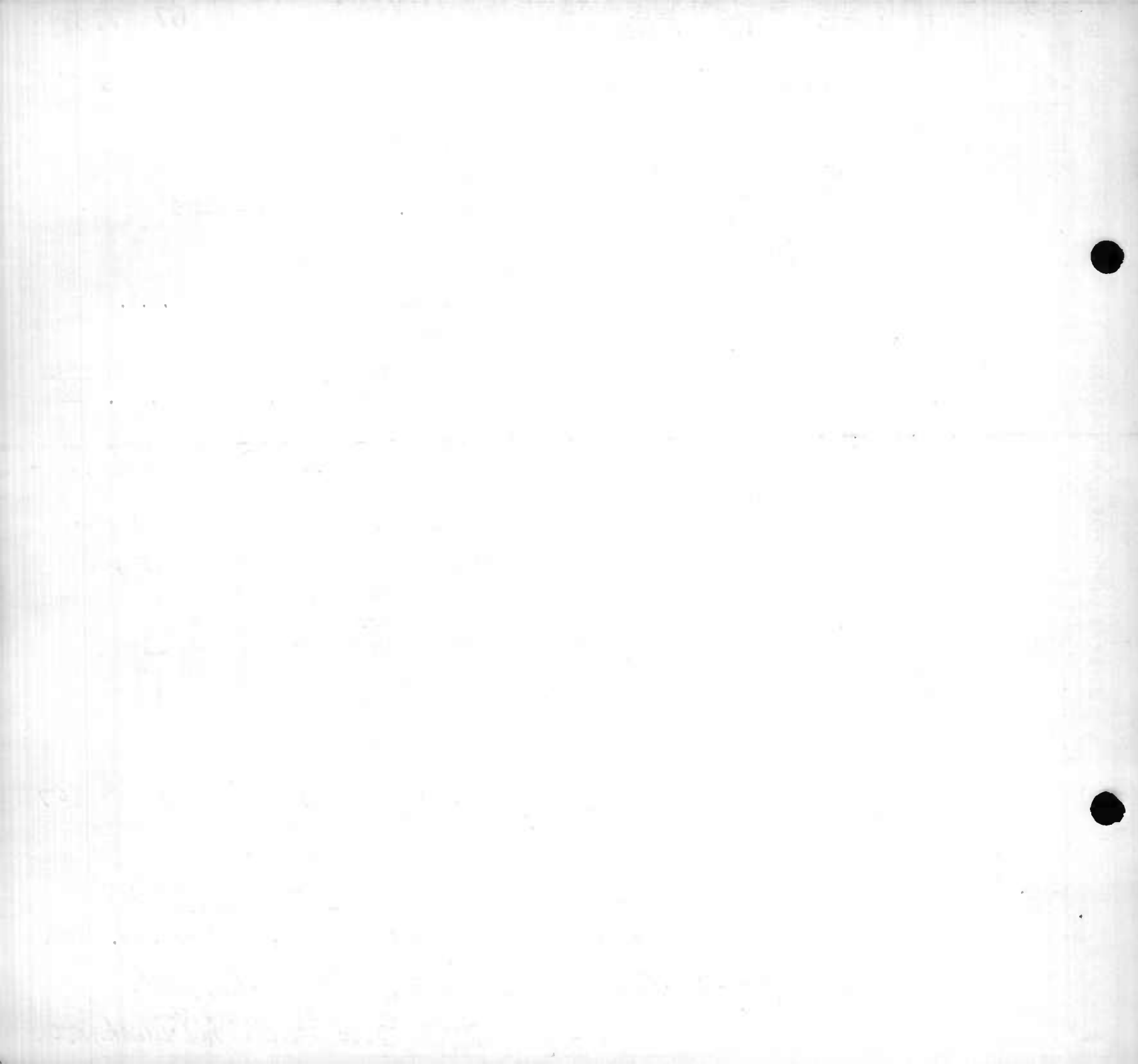
8/1/02

Mr. O. O. O.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-620 67 7767		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7767	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				JOHN H. HARRIS	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
8/7/67 5:30 A.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
		BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		MARYLAND	
5. SEX		6. RACE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
MALE		NEGRO		BALTIMORE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
WIDOWED		5/1/1869		98	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN H. HARRIS		ANNIE		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 I		(A) Probable pneumonia		4 days	
ANTECEDENT CAUSES		(B) multiple CVA's		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD		35 yrs.	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		possible pneumothorax	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/27 1967 to 8/7 1967, that (I) (we) lost saw the deceased alive on 8/7/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. M. Levinsohn M.D.				8/7/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E. M. Levinsohn		BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/12/67		Brewer Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 15 1967		R. E. Taylor		James Butler Jones, Funeral Home 3800 Har. Ave. NW, Wash., D.C.	



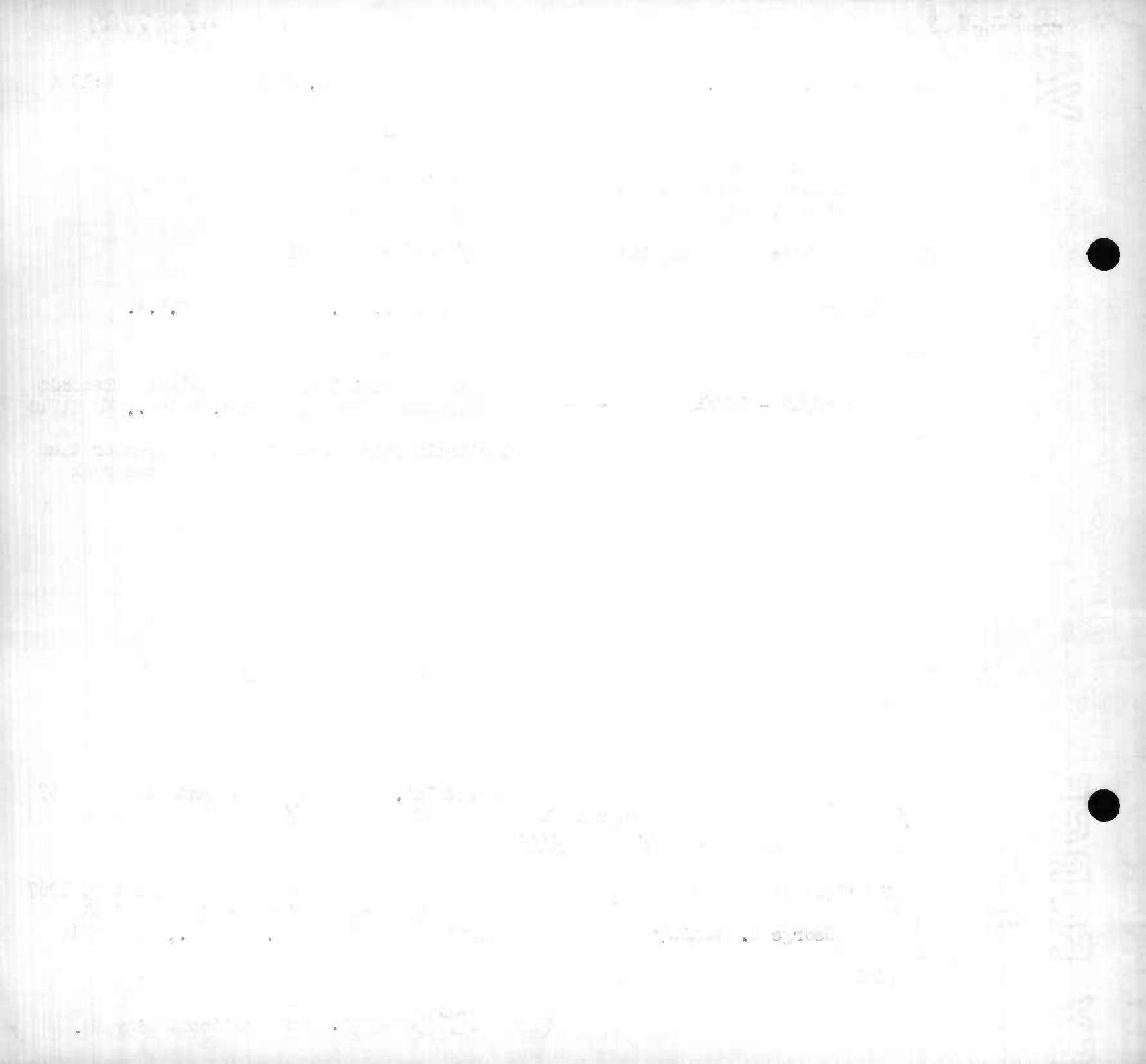
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Frederick, Md 67 7768</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 7768</u>	
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Raymond Nelson Frye, II</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>August 10, 1967</u> </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital, Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Frederick</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Rural - Frederick</u> D. STREET ADDRESS (If rural, give location) <u>Route 6, Frederick, Maryland</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>March 5, 1963</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Raymond Nelson Frye, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Myra Eleanor Tobery</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Raymond Nelson Frye, Sr. Rt. 6, Frederick, Md.</u>		
18. <u>344.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>internal hydrocephalus</u> DUE TO (B) <u>stenosis of aqueduct</u> DUE TO (C) <u>Pandy Walker malformation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>Respiratory distress 2nd to Aspiration</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> 19 <u>67</u> to <u>Aug 10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 9</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>O. Polanco</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/10/67</u>
23C. PHYSICIAN'S NAME (Type) <u>Octavio Polanco</u>			23D. ADDRESS <u>Mercy Hospital, Balto, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/12/67</u>	24C. NAME of CEMETERY or CREMATORY <u>Mount Olivet Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
25A. DATE REC'D <u>AUG 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Md.</u>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7769				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7769	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOUSE, HARRY B.				2. DATE AND HOUR OF DEATH August 9, 1967 8:10 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ellicott City D. STREET ADDRESS (If rural, give location) 139 Columbia Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/30/95	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Laurel, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry B House				14. MOTHER'S MAIDEN NAME Laura MacAbee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/26/18 - 6/7/19		16. SOCIAL SECURITY NO. 212-32-3165A		17. INFORMANT ADDRESS Veterans Administration Hospital Records 3900 Loch Raven Boulevard, Balto., Md 21218			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH greater than one week	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that 1 (this hospital) attended the deceased from August 1st. 19 67 to August 9th 19 67 , that 1 (we) last saw the deceased alive on August 9th 19 67 and that in 1 (our) opinion death occurred on the date and hour and from the causes stated above. 1 (We) (did) (d/d/d) view the body after death.							
23A. SIGNATURE George W. Gaffney M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED August 9, 1967			
23C. PHYSICIAN'S NAME (Type) George W. Gaffney		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/12/67		24C. NAME of CEMETERY or CREMATORY Crest Lawn		24D. LOCATION (City, town, or county) (State) Alpha Howard Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Slack ADDRESS Ellicott City Md.			



67 7770

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7770

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)L.
DEWEY DUNCAN

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1967 10:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3372 Dulaney Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 9, 1898

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Duncan

14. MOTHER'S MAIDEN NAME

Margaret

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

233-09-5682

17. INFORMANT

ADDRESS

Mrs. Lola T. Duncan, 3372 Dulaney St. 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-67

23C. NAME of CEMETERY or CREMATORY

Meadowridge Cemetery

23D. LOCATION

(City, town, or county)

(State)

Howard County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

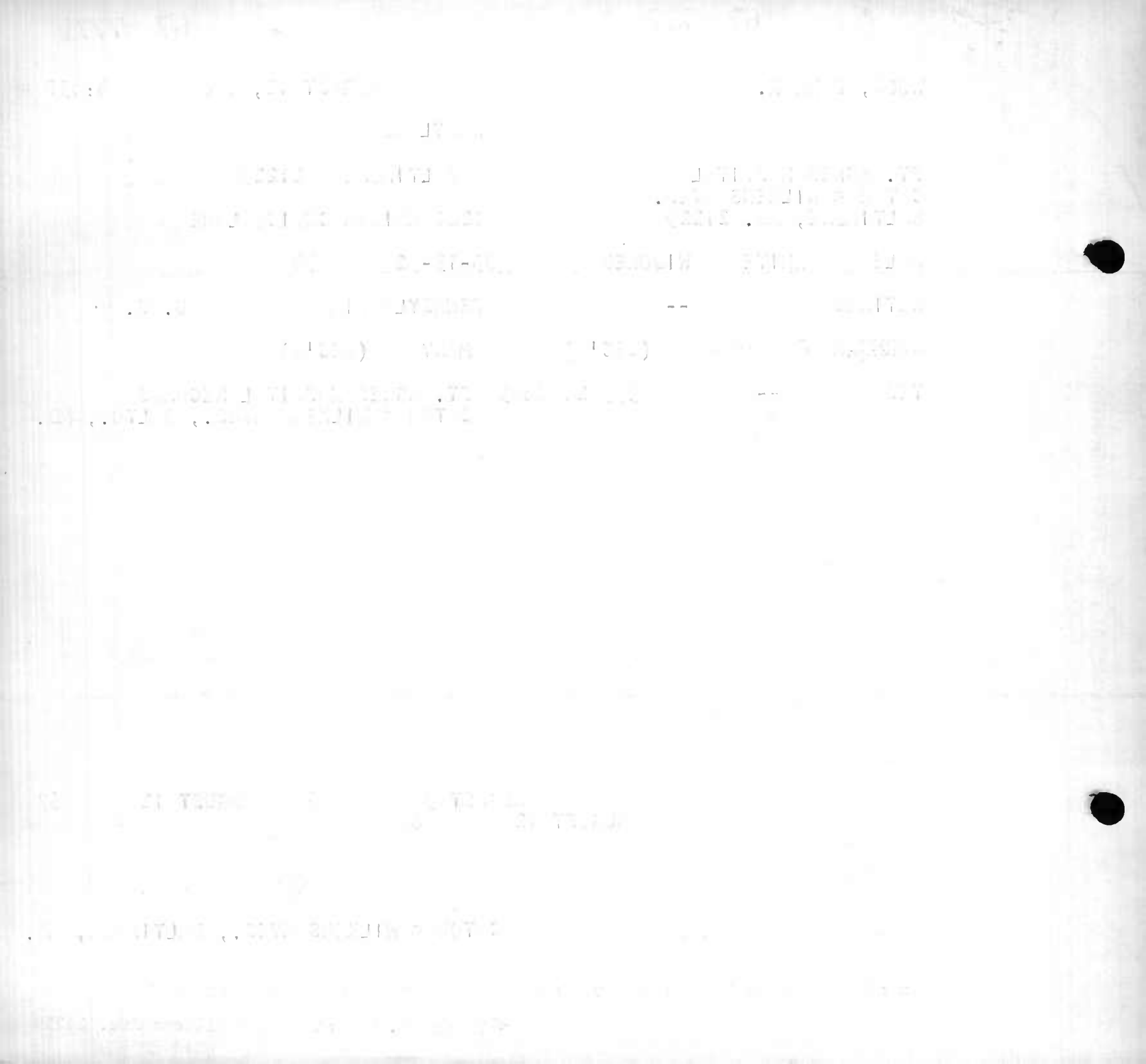
Howard H. Hubbard, 4107 Wilkens Ave. 21229

SECRET
NO FORN DISSEM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City and Health Department CERTIFICATE OF DEATH				Registered No. 67 7771	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) WOOD, JOHN H.				2. DATE AND HOUR OF DEATH AUGUST 12, 1967 4:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229	
				D. STREET ADDRESS (If rural, give location) 1201 MAIDEN CHOICE LANE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 09-13-92	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME XXXXXXXXXX John Wood (DEC'D)			14. MOTHER'S MAIDEN NAME MARY (DEC'D)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, name and branch) (If yes, give war or dates of service) YES W W I			16. SOCIAL SECURITY NO. 577 24 8483		
17. INFORMANT ST. AGNES HOSPITAL RECORDS CATON & WILKENS AVES. BALTO., MD.			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute leukemia			CAUSE OF DEATH (A) DUE TO Diabetes Mellitus		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 9 19 67 to AUGUST 12 19 67 , that (I) (we) last saw the deceased alive on AUGUST 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paulino O. Vasallo</i>				23B. DATE SIGNED 8-12-67	
23C. PHYSICIAN'S NAME (Type) Paulino O. Vasallo				23D. ADDRESS CATON & WILKENS AVES., BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-67		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard	
				ADDRESS 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7772				67 7772		67 7772	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) CHARLES STURM				2. DATE AND HOUR OF DEATH 8/12/67 - 1 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL 110 CALHOUN ST. BALTO. MD.				A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-05 D. STREET ADDRESS (If rural, give location) 2121 RAMSAY ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/12/94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Molder			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Sturm			14. MOTHER'S MAIDEN NAME ANNIE SCHULTZIE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-09-8870		17. INFORMANT Mr. Charles A. Sturm, Sr. 300 Haile Ave. 21225		
18. CAUSE OF DEATH							
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE				INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS			
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 11 1967 to AUGUST 12 1967 , that (I) (we) last saw the deceased alive on AUGUST 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/67	
23C. PHYSICIAN'S NAME (Type) PLACIDO MACARAE G JR.				23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

FRANKLIN SQUARE
110 COLUMBIA ST
BOSTON, MD

Mrs. WHITE
Widow

MARY AND

ANNE JENNINGS

CONGRATULATE

RECEIVED

August 11
1902

8/11/02



FRANKLIN SQUARE

B-152

67

7773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67

7773

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BEVANS GAIL H. BEVANS

2. DATE AND HOUR OF DEATH

8-13-67

7:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue Baltimore, Md. #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

216 S. Eden St. #21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-1-41

9. AGE (In years
last birthday)

25

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Manager

10B. KIND OF BUSINESS OR INDUSTRY

Pool Hall

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Bevans

14. MOTHER'S MAIDEN NAME

Maxine Hollinger

15. Was Deceased Ever in U. S. Armed Forces?

No

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-44-0446

17. INFORMANT

RECORDS:

BCM 4940 Eastern Avenue ADDRESS

Baltimore, Md. #21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) liver failure
DUE TO(B) alcoholic cirrhosis
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 8/11 1967 to 8/13 1967,
that ~~we~~ (we) last saw the deceased alive on 8/13 1967 and that in ~~our~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~we~~ (We) (did) ~~view~~ view the body after death.

23A. SIGNATURE

Monica M. Buckley

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/13/67

23C. PHYSICIAN'S
NAME (Type)

Monica M. Buckley

M.D.

23D. ADDRESS
4940 Eastern Avenue Baltimore, Md. #2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/16/67

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

25B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

about the center
river features

see

4/12

4/11

4/10

4/9

Wm. M. [unclear]
[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7774				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7774	
1. NAME OF DECEASED (Type or Print) REUBEN ABRAHAM FRIEDMAN				2. DATE AND HOUR OF DEATH AUG 13, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 INAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-19 D. STREET ADDRESS (If rural, give location) 5806 JONGUIL AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN 26, 1906	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTO, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME YOMTOV			14. MOTHER'S MAIDEN NAME EVA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 214-40-4123		17. INFORMANT LEAH FRIEDMAN		ADDRESS SAME	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A-5 HT Dis				CAUSE OF DEATH (A) Acute coronary occlusion DUE TO (B) A-5 HT Dis DUE TO (C) —		INTERVAL BETWEEN ONSET AND DEATH 5-10 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-27- 19 61 to 11-2- 19 64 , that (I) (we) last saw the deceased alive on 11-2- 19 64 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. M. WAGHELSTEIN				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-14-67	
23C. PHYSICIAN'S NAME (Type) J. M. WAGHELSTEIN				23D. ADDRESS 1010 St Paul St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/14/67		24C. NAME OF CEMETERY or CREMATORY B NAI ISRAEL		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Stanley		25C. FUNERAL DIRECTOR Sylvanus S. Lewis & Son Inc			



67 7775

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7775

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SHIRLEY LEE DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1967 2:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Virginia B. COUNTY Loudoun

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Purcellville (Rural Route # 2)

D. STREET ADDRESS (If rural, give location)

Box 81

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 1, 1936

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Abattoir

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Prince Albert Davis

14. MOTHER'S MAIDEN NAME

Nancy Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

231-48-2096

17. INFORMANT

ADDRESS

P. Albert Davis Purcellville, Va.

18.

E819.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-Cerebral Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
TO CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Hwy 17 - 1000 ft. N. of Virginia Line

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour) (Minute)
August 5, '67 10:40 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subj. driver swerved to
prevent accident - struck a bridge.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-15-1967

23C. NAME of CEMETERY or CREMATORY

Lincoln Cemetery

23D. LOCATION

(City, town, or county)

(State)

Lincoln, Virginia

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

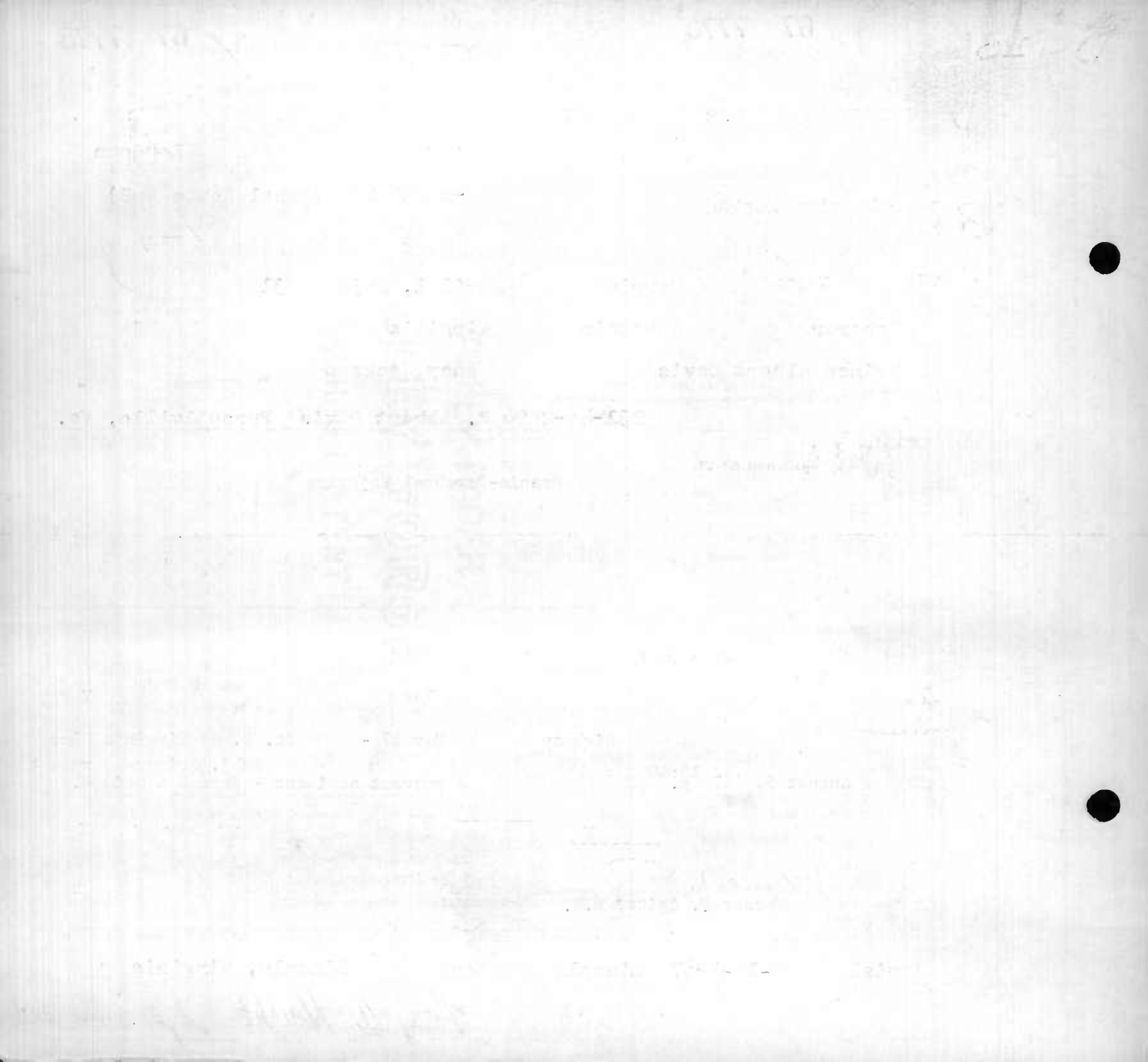
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Harry W. Haight

ADDRESS

Lynchville, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7776				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7776	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILMER BARNES				2. DATE AND HOUR OF DEATH 8-12-67 3.35 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4009 Biddison Lane			
5. SEX Male	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/30/06	9. AGE (in years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10B. KIND OF BUSINESS OR INDUSTRY U.S.F.G.		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wilmer Barnes				14. MOTHER'S MAIDEN NAME Minnie Schneider			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2		16. SOCIAL SECURITY NO. 215078430		17. INFORMANT Mrs. Eveleyn Barnes		ADDRESS Same	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) acute myocardial infarction				CAUSE OF DEATH (A) DUE TO coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO aspiration pneumonia, CHF			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8:30 PM August 11 1967 to August 12 1967 , that (I) (we) last saw the deceased alive on 3:35 AM Aug. 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fernando Canon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-12-67	
23C. PHYSICIAN'S NAME (Type) FERNANDO CANON				23D. ADDRESS M.D. Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/67		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd 21214			

Fernando Canon

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7777				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7777	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				CATHERINE A CURRERA		8/13/67 7:10 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND			
48 MARYLAND GENERAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
				D. STREET ADDRESS (If rural, give location)		27-09 4204 LOCK RAVEN BLVD.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Female	White	Widowed	9/1/01	65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Housewife			-		Baltimore, Md.		
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Peter A. LEONE (Lion)				CATHERINE LEONE Montemurro			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Acute Myocardial Infarction 8 days	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 12, 1967 to August 13, 1967, that (I) (we) last saw the deceased alive on August 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. A. Bard M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/13/67	
23C. PHYSICIAN'S NAME (Type) RICHARD A. BARD M.D.				23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Salisbury		25C. FUNERAL DIRECTOR ADDRESS		Leonard J. Ruck Inc. 5305 Harford	

CONFIDENTIAL

RECEIVED AND GENERAL INVESTIGATION

WEEKLY NEWS SERVICE

9/1/61 42

WEEKLY NEWS SERVICE

RECEIVED

CONFIDENTIAL

NO

RECEIVED AND GENERAL INVESTIGATION

NO

R. A. [Signature]

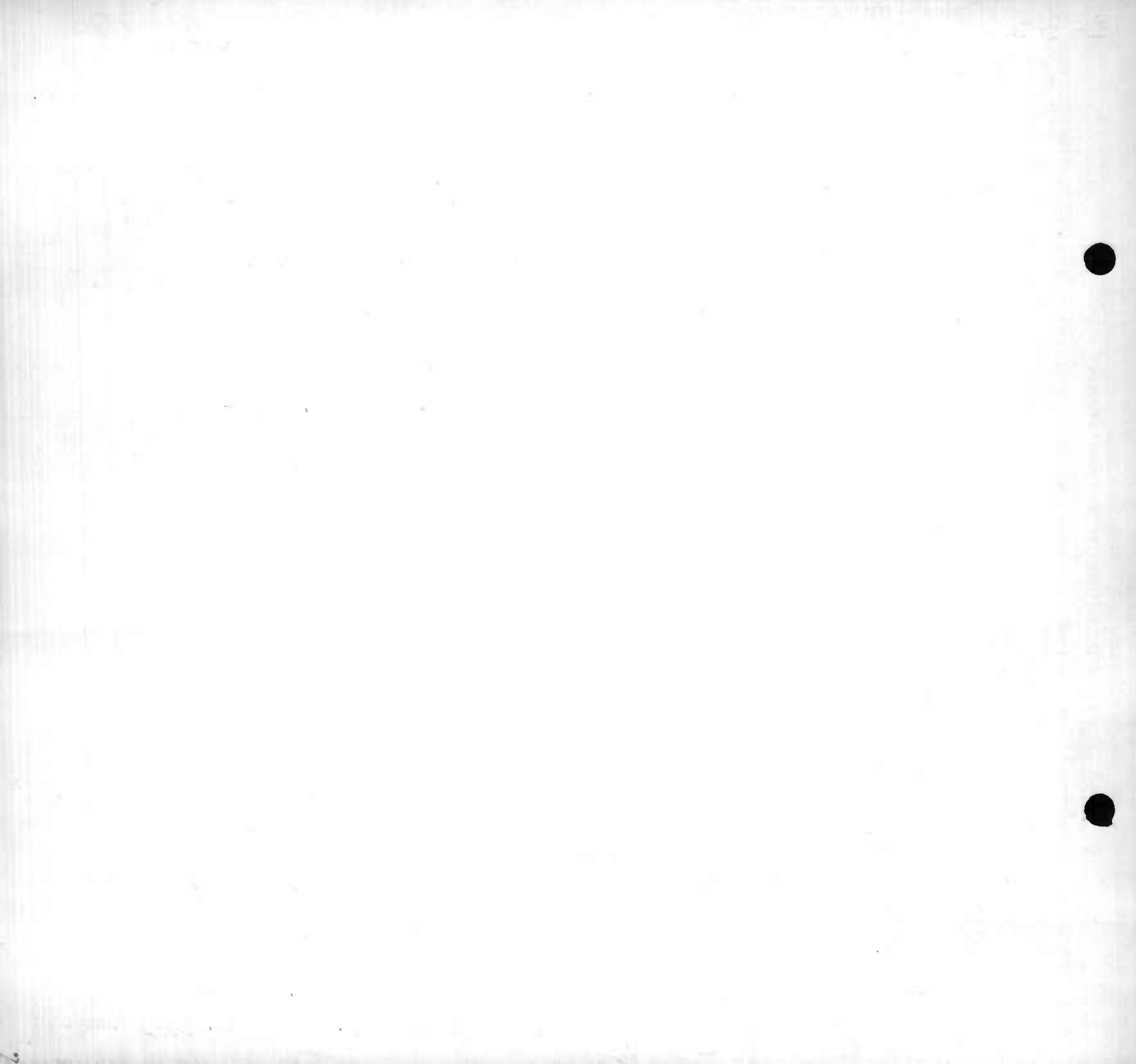
RECEIVED & SENT

RECEIVED AND GENERAL INVESTIGATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

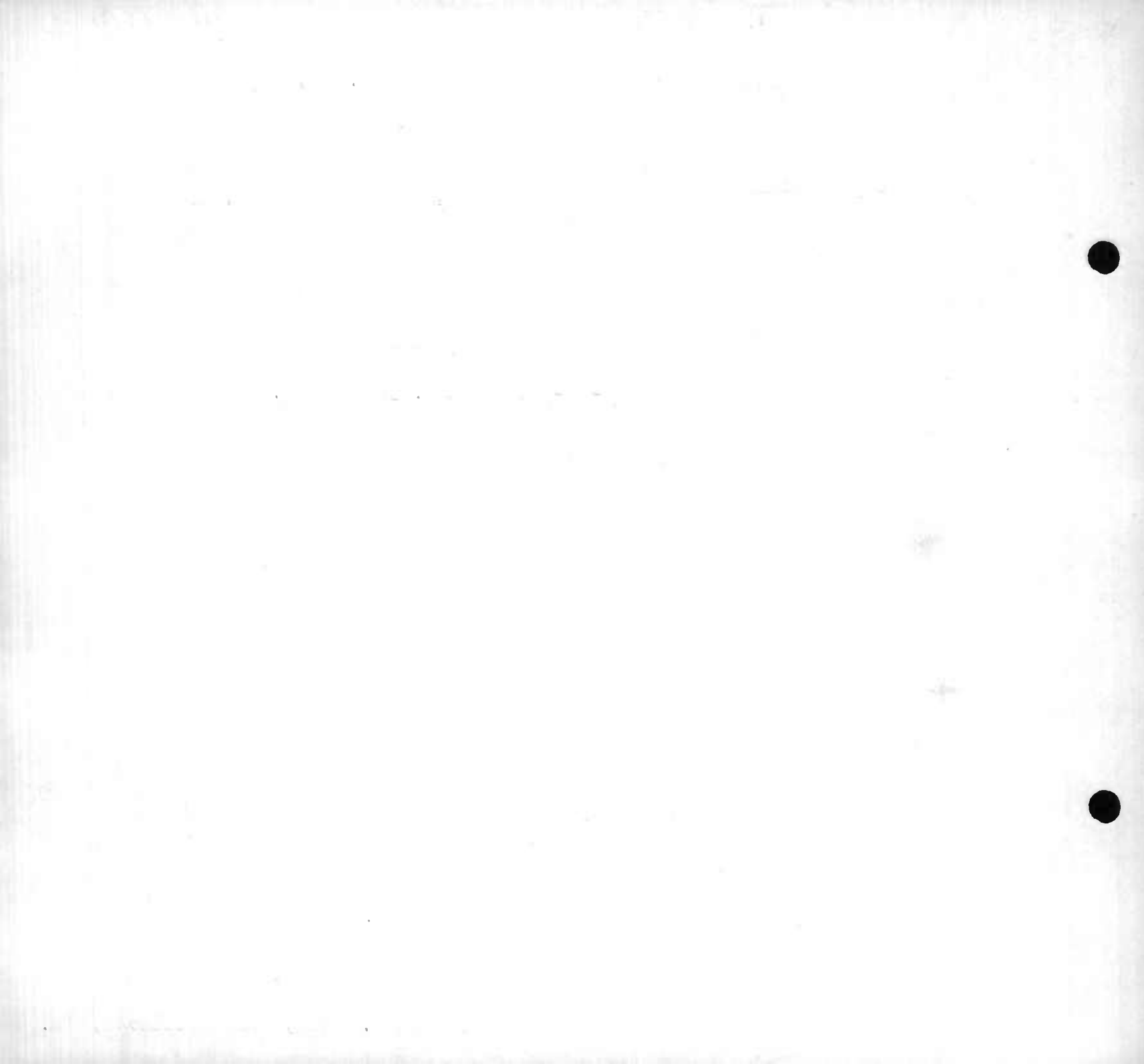
BIRTH NO. 67 7778		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7778	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Constable, Charles B</i>		2. DATE AND HOUR OF DEATH <i>8-13-67</i> <i>A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> # <i>212 34</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>82 31 Bon Air Road</i>	
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>8-8-86</i>	9. AGE (In years, last birth) <i>81 yrs.</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Glenn L. Martin</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Constable, Charles</i>		14. MOTHER'S MAIDEN NAME <i>Gibson, Clara</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>WW2</i>		16. SOCIAL SECURITY NO. <i>213-14-4183</i>		17. INFORMANT <i>Mrs. Janet M. Sipe - Same</i>	
18. <i>163 X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>3 MONTH</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <i>CARCINOMA OF THE LUNG</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>7-28 1967</i> to <i>8-13 1967</i> , that (I) (we) last saw the deceased alive on <i>8-13 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Badam</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/13/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Goldgeier, Sheldon (attending)</i>		23D. ADDRESS <i>848 W. 36th St. 21218</i>			
24A. BURIAL CREATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/16/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert B. Farley</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		ADDRESS <i>5305 Harford</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7779		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7779	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Donald L Bond		2. DATE AND HOUR OF DEATH Aug. 12, 1967 2:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4838 Greencrest Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore 26-34 D. STREET ADDRESS (If rural, give location) 4838 Greencrest Road			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/4/12	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Father		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Woodlawn Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clarence Bond		14. MOTHER'S MAIDEN NAME Esther Geist			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 217-01-7185		17. INFORMANT Mrs. Frances E. Bond	
				ADDRESS Same	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Coronary occlusion DUE TO (B) Anterior chest C.V. disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 10 1967 to Aug. 12 1967, that (I) (we) last saw the deceased alive on Aug. 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Grenger				23B. DATE SIGNED 8.14.67	
23C. PHYSICIAN'S NAME (Type) WM. H. GRENGER				23D. ADDRESS M.D. 1520 E. 33rd St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 7780		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7780	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HEINRICH KNOCHENHAUER		2. DATE AND HOUR OF DEATH 8/12/67 12:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6601 SEFTON AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 4/29/95	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? RUSSIA
13. FATHER'S NAME NOT KNOWN		14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-30-8877		17. INFORMANT Miss ARIANE SVECHNIKOV ADDRESS 6601 SEFTON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Heart Failure Aortic Stenosis (arteriosclerosis) (A) DUE TO Coronary Atherosclerosis (B) DUE TO (C) DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 7 19 67 to August 12 19 67, that (I) (we) last saw the deceased alive on August 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Cipriani		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/67	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI		23D. ADDRESS M.D. 33rd and CALVERT ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/67		24C. NAME of CEMETERY or CREMATORY Moreland Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Buck Inc. Balto. Md.			

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FUNERAL DIRECTOR: IMPORTANT

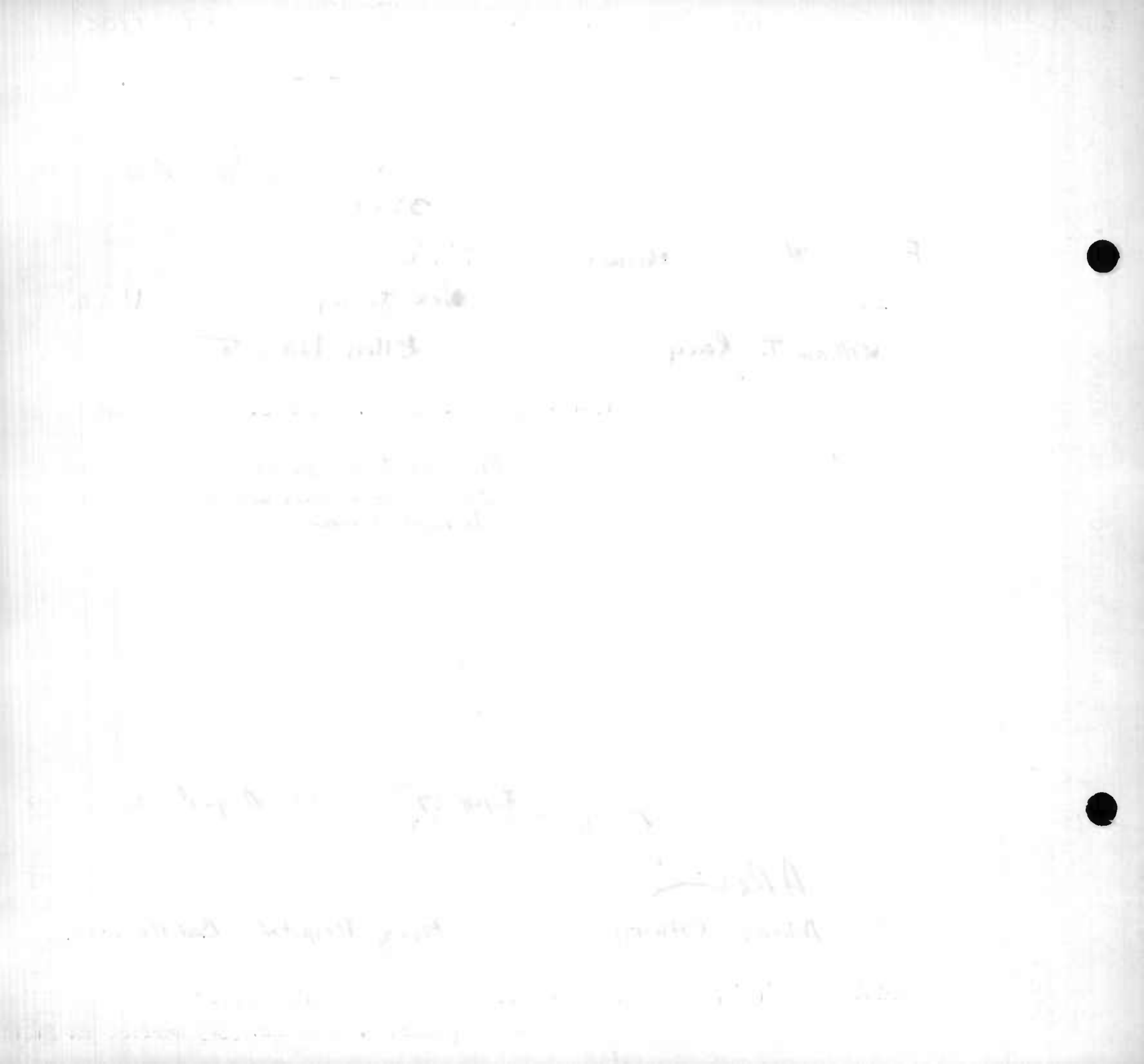
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7781		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7781	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GEORGE A. KUHL			2. DATE AND HOUR OF DEATH AUGUST 12 1967 9:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-11 D. STREET ADDRESS (If rural, give location) 506 S. EAST AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEPT 6, 1905	9. AGE (in years last birthday) 61	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABLE SPlicer		10B. KIND OF BUSINESS OR INDUSTRY CYPT TELEPHONE Co of Md.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Thomas Kuhl			14. MOTHER'S MAIDEN NAME Barbara Sperlein		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0949		17. INFORMANT MELITO M. TORRES, M.D.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) 162.1 I		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH Acute bronchopneumonia + bacterial (A) DUE TO endocarditis + multiple infarcts of (B) DUE TO kidney + spleen (C) Baonchogenic carcinoma			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from AUGUST 11, 1967 to AUGUST 12 1967 , that (H) (we) last saw the deceased alive on AUGUST 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Melito M. Torres, M.D.		23D. ADDRESS 441 S. ELLWOOD AVE., BALTIMORE, 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/16/67	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR Robert E. Taylor, MA	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

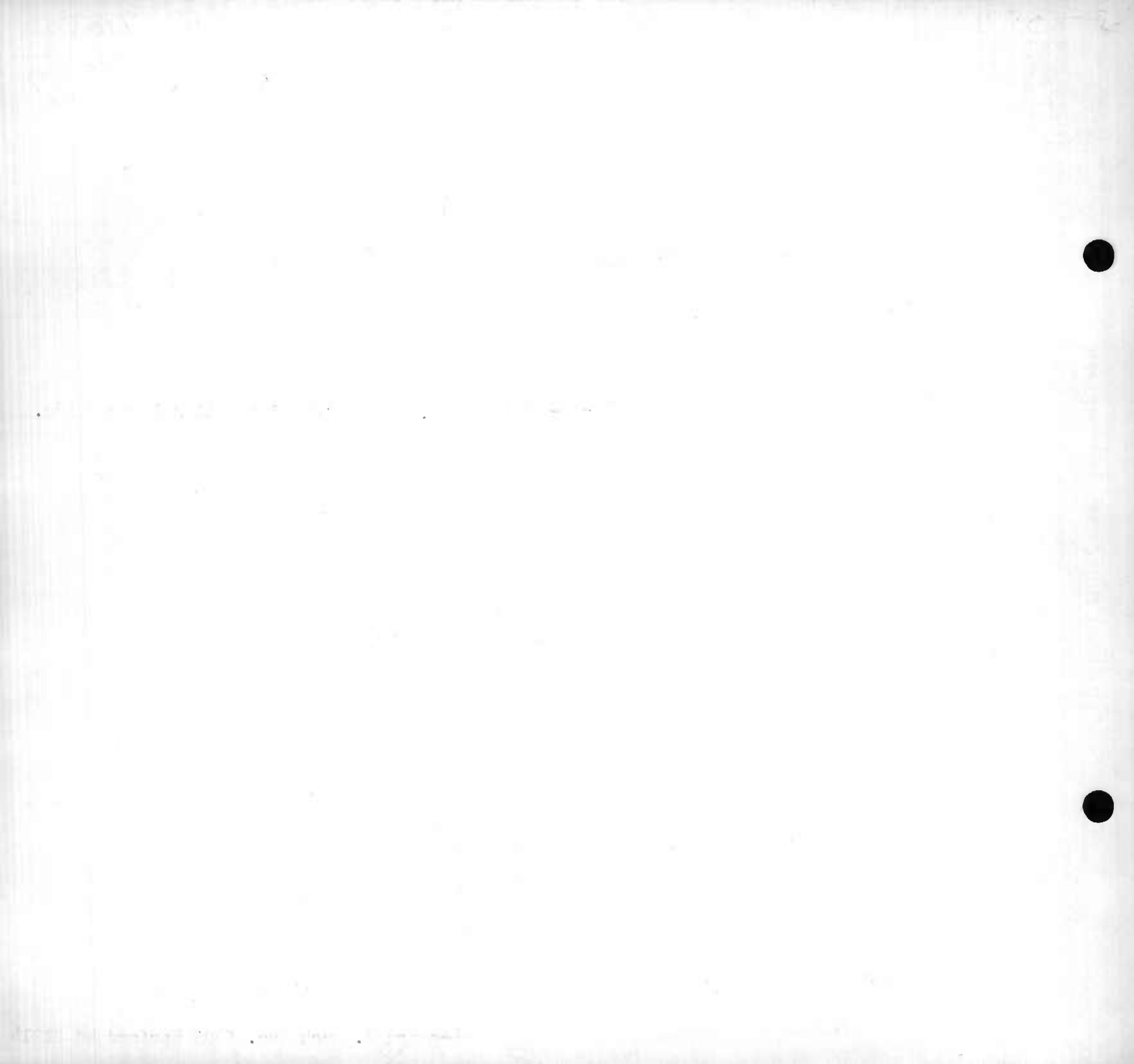
BIRTH NO. 67 7782		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7782	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) LORENE LANGE		
2. DATE AND HOUR OF DEATH 8-12-67 11.35 AM			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 27-12-62 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rosekemp Ave Bal MD D. STREET ADDRESS (If rural, give location) 3203		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/27/13	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William T. Reay		
14. MOTHER'S MAIDEN NAME Ellen Hamilton			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-18-2949			17. INFORMANT Mr. Fred A. Lange Sr. ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Electrolyte imbalances and cancer metastasizing to breasts (B) breast cancer (C)		
INTERVAL BETWEEN ONSET AND DEATH			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 8/16/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 27 1967 to August 12 1967, that (I) (we) last saw the deceased alive on 5 pm 8/11/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Abbas RAHIM			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Abbas RAHIM			23D. ADDRESS Mercy Hospital Bal MD 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/67		24C. NAME OF CEMETERY or CREMATORY Dulaney b Valley	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967	
25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR		25D. ADDRESS 5305 Narford Rd. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

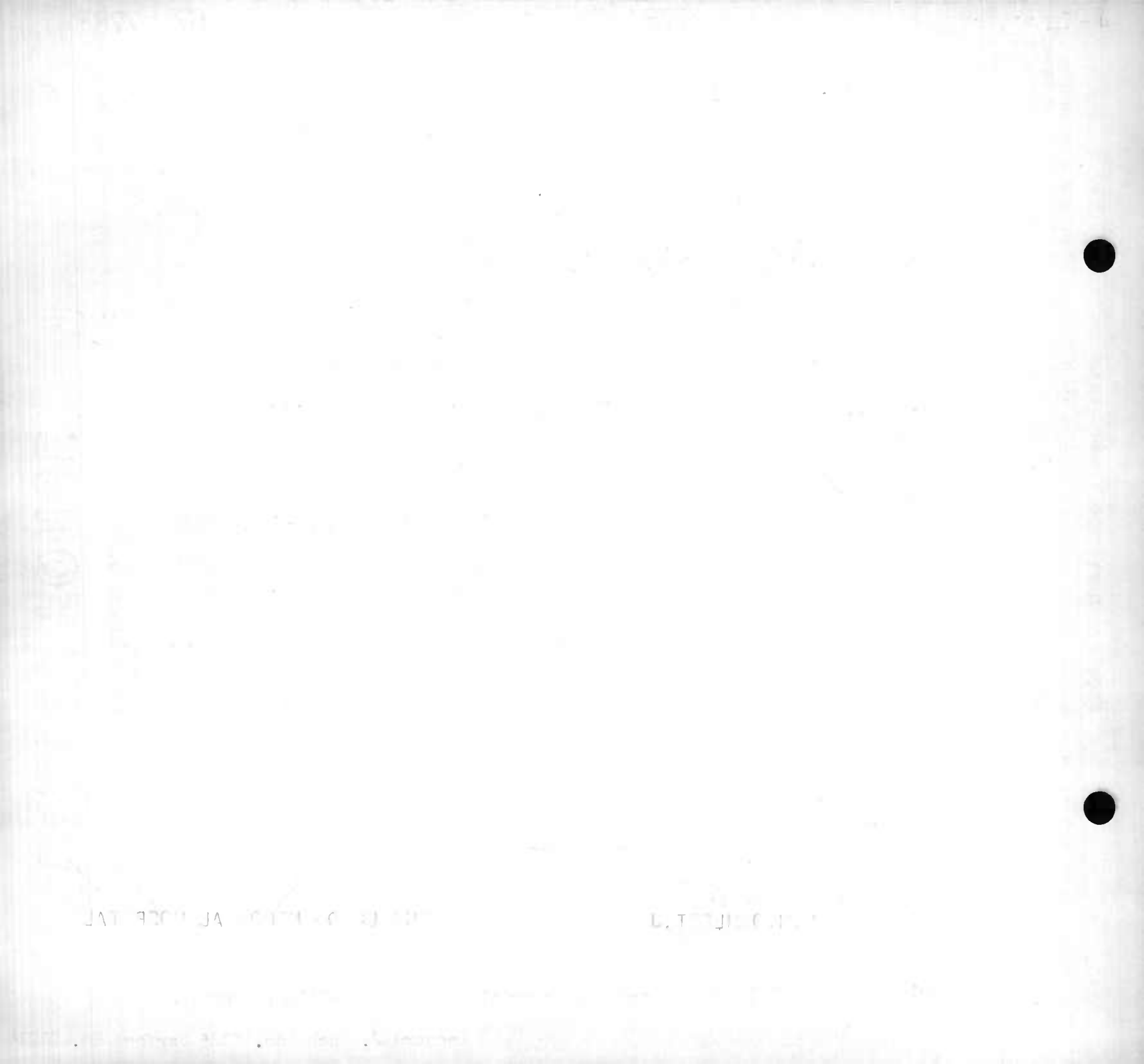
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7783		CERTIFICATE OF DEATH		67 7783	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr. George Stein (STEIN)		2. DATE AND HOUR OF DEATH 8/11/1967 8:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Hood Conv. Home		A. STATE MD. B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt. 6-02			
		D. STREET ADDRESS (If rural, give location) 2411 Jefferson St.			
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct 1, 1884	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MFG Mens Pagama Coy.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balt.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Stein		14. MOTHER'S MAIDEN NAME Gam ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-6459		17. INFORMANT John H. Herold	
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A.S.H.D. Generalized Atherosclerosis			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30/1967 to 8/11/1967 , that (I) (we) last saw the deceased alive on 8/11/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adnan Sonmez M.D.				23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) Adnan Sonmez				23D. ADDRESS 1011 Frederick Road.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/15/67		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Leonard J. Buck Inc.	
				ADDRESS 5305 Harford Rd 21214	



FUNERAL DIRECTOR: IMPORTANT

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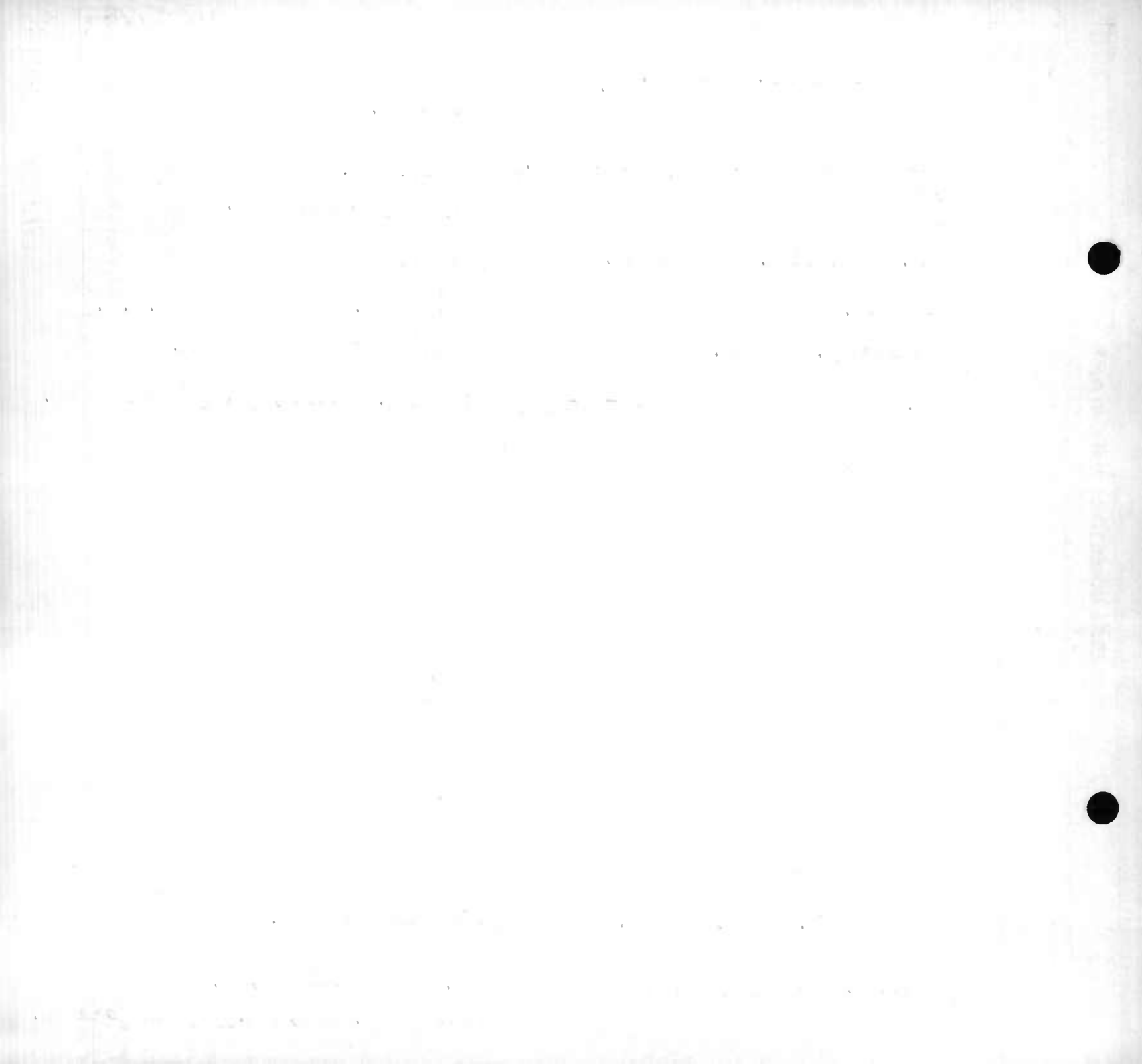
BIRTH NO. 67 7784		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7784	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ABE JOSEPH		2. DATE AND HOUR OF DEATH 8/11/67 7 30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21-44	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp.		D. STREET ADDRESS (If rural, give location) 5934 GLEN OAK AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/9/98	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PALESTINE	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? AMERICA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 218-32-3085		17. INFORMANT HOSPITAL ADMISSION HISTORY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 526X I		CAUSE OF DEATH (A) DUE TO BRONCHOPNEUMONIA Bronchiectasis (B) DUE TO COPD PULMONARY (C) DUE TO PULMONARY EMPHYSEMA Chronic		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 5 YEARS 15 YEARS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC ASTHMATIC BRONCHITIS		15 YEARS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/28 19 67 to 8/11 19 67 , that (I) last saw the deceased alive on 8/11 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Oehlert, Jr.				23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) W. H. Oehlert		23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.			
25D. ADDRESS 5305 Harford Rd.		25E. ADDRESS 21214			



FUNERAL DIRECTOR: IMPORTANT

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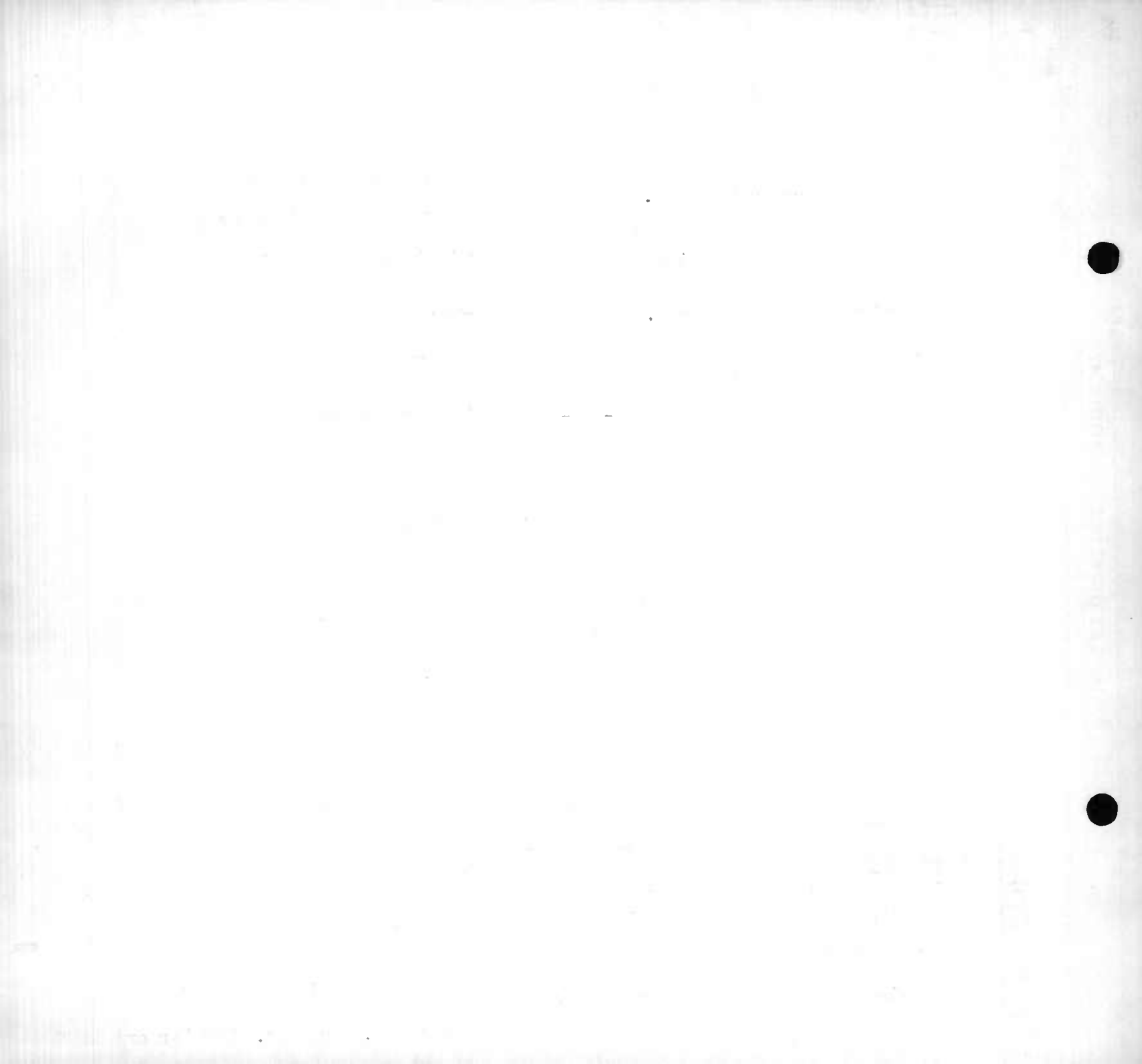
BIRTH NO. 67 7785				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7785	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Rudolph F. Zerner, Sr.</i>				2. DATE AND HOUR OF DEATH <i>8/11/67</i> <i>4:00 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>House in the Pines (Belair RD.)</i> <i>90</i>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) <i>Maryland</i> COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore.</i> <i>27-01</i>			
				D. STREET ADDRESS (If rural, give location) <i>2908 Gibbons Ave.</i>			
5. SEX <i>Male.</i>	6. RACE <i>White.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widower.</i>	8. DATE OF BIRTH <i>3/12/1901</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Surveyor.</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Rudolph G. Zerner.</i>			14. MOTHER'S MAIDEN NAME <i>Lollie Loretta Bagwell.</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>			16. SOCIAL SECURITY NO. <i>212-12-6959</i>		17. INFORMANT ADDRESS <i>Joseph E. Zerner, 2908 Gibbons Ave.</i>		
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>B.H. Lung</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 11, 1967</i> to <i>Aug. 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug. 11, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Nathan Jarney</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/12/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Nathan Jarney.</i>				23D. ADDRESS <i>7101 Harford Rd.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial.</i>		24B. DATE <i>8/14/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 7786				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7786	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Paul Peter Kopeck		8/11/1967 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
00 5601 Summerfield Ave.				Baltimore Maryland		D. STREET ADDRESS (If rural, give location)	
5601 Summerfield Avenue				5. SEX		6. RACE	
Male				W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Widowed				8. DATE OF BIRTH		9. AGE (In years last birthday)	
11/12/1885				81		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Beth. Steel		Poland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
Frank Kopeck				14. MOTHER'S MAIDEN NAME			
Mary ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT			
02-006-0850				Miss Anna Kopeck			
Same				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO				Coronary Thrombosis 2 hrs.			
(B) DUE TO				Arteriosclerotic Cardiovascular disease 12 years			
(C) DUE TO							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None			
MEDICAL CERTIFICATION				19A. DATE OF OPERATION			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from				March 1958 to 8/11/1967			
that (I) (we) last saw the deceased alive on				8/11/1967			
and that in (my) (our) opinion death occurred on the date				and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
William J. Vitale				8/11/1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
6900 Borden Avenue, Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				8/14/67			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Holy Rosary				Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
AUG 15 1967				Robert E. Feltner			
25C. FUNERAL DIRECTOR				25D. ADDRESS			
Leonard J. Ruck Inc.				5305 Harford Rd 21214			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7787		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7787	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
		Ira W. Springer		Aug. 11, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
House In The Pines Nursing Home Belvedere				Md.			
5. SEX				6. RACE			
Male				Cau.			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Married				Nov. 14, 1896			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Foreman				Hagerstown, Maryland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Chemical Laboratory							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Springer				Martha Swope			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
yes W #1				214-09-8215			
17. INFORMANT				ADDRESS			
Mrs. Alice Walker, 3721 W. Garrison Ave.							
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
Pneumonia				3 days			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arterio-sclerotic Heart Disease			
				3 years			
				(C) DUE TO			
				Portner Disease			
				5 years			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Jun 21 1966 to Aug 11 1967, that (I) (we) last saw the deceased alive on Aug 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Manuel Levin						8/14/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Manuel Levin, M.D.				6101 Park Heights Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/15/1967		Glen Haven Cemetery		Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1967		Robert E. Fairman		G. Vernon Lemmon		4611 Park Heights Ave.	

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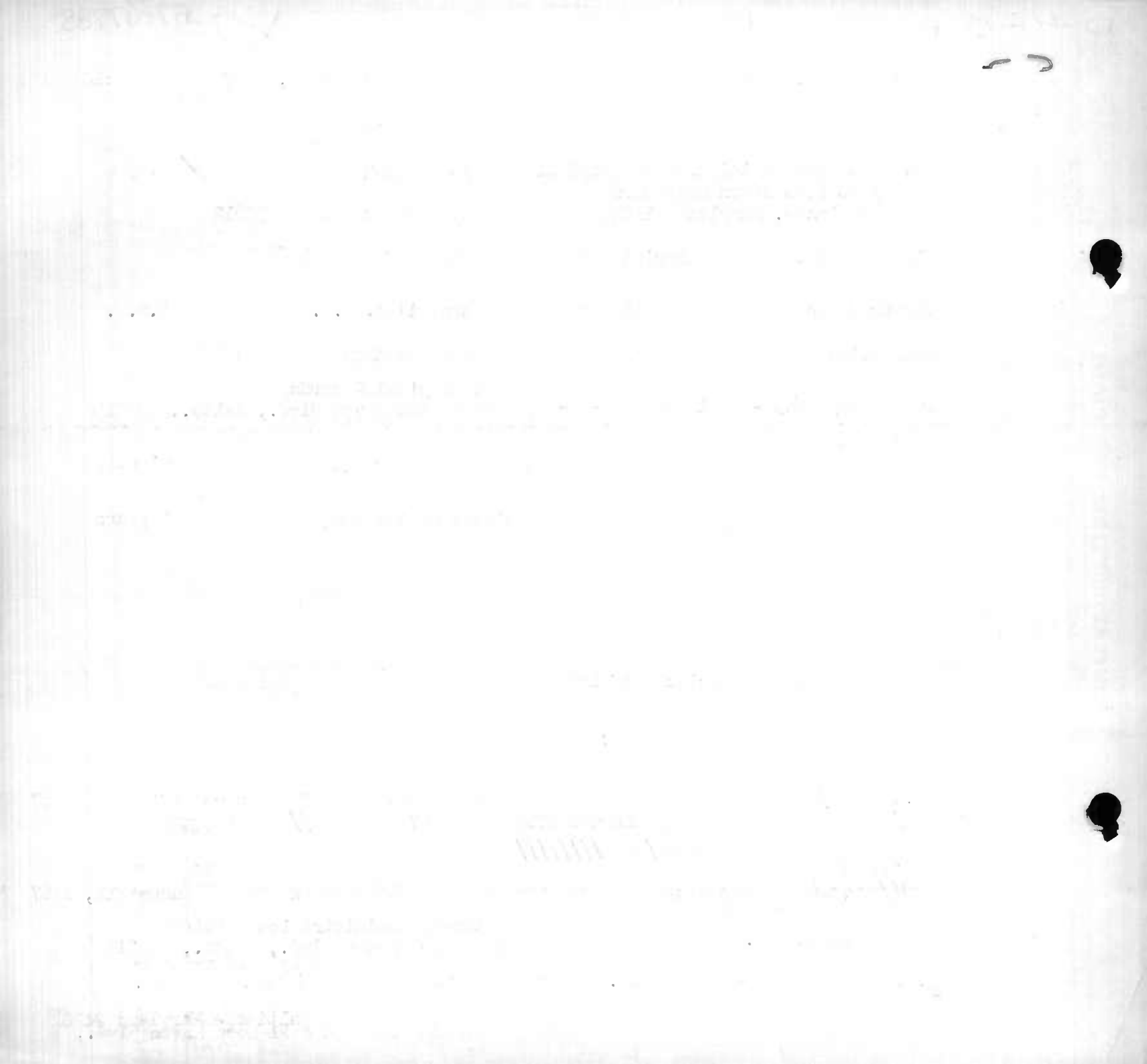
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7788		67 7788		67 7788	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		BOLICK, Elzie Eugene		August 10, 1967 8:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
27 Veterans Administration Hospital		California			
3900 Loch Raven Boulevard		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Baltimore, Maryland 21218		Long Beach		K-04	
		D. STREET ADDRESS (If rural, give location)			
		319 Hermosa Avenue 90812			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	Married	1/28/27	40	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Construction		Building		Burnsville, N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Tom Bolick		Mandy McMahan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 11/21/45 - 12/12/46		243-30-8674		VA Hospital Records	
				3900 Loch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Pulmonary Hemorrhage		minutes	
ANTECEDENT CAUSES		(B) Carcinoma of the Lung		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
May 1965	Carcinoma of lung	Yes	Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (this hospital) attended the deceased from February 9th 19 67 to August 10th 19 67, that (we) last saw the deceased alive on August 10th 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael G. Hayes				August 11, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MICHAEL G. HAYES		Veterans Administration Hospital			
		3900 Loch Raven Blvd., Balto., Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City and county) (State)	
Burial	8-14-67	Baltimore National Cemetery		Holly Hill Cemetery Baltimore, Maryland.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1967	Robert E. Taylor	WILLIAM JOHNSON		Baltimore Maryland 21204	
				8521 Loch Raven Blvd.,	



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J-525

67 7789

BALTIMORE CITY HEALTH DEPARTMENT

67 7789

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROBERT R. JOHNSON				2. DATE AND HOUR PRONOUNCED DEAD August 10, 1967 7:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Square Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 220 N. Stricker St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	B. DATE OF BIRTH Nov. 8, 1932	9. AGE (In years last birthday) 34	11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aid		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Johnson				14. MOTHER'S MAIDEN NAME Lillian Dixon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes 1953-1955		16. SOCIAL SECURITY NO. 214-28-9035		17. INFORMANT Mother ADDRESS Mrs. Lillian Johnson-La Plata, Maryland			
18. E 982 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive Internal Bleeding due to Stab wounds of chest and abdomen with involvement of right lung, liver, and vena cava.				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 220 N. Stricker St. 19-02			
21D. TIME OF INJURY (APPROX.) 8/10/67 5L15 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Stabbed during an argument			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/11/67	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/14/1967		23C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery		23D. LOCATION (City, town, or county) (State) La Plata, Maryland	
24A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		24B. NAME OF REGISTRAR Robert E. Farley, MA		24C. FUNERAL DIRECTOR Arehart Funeral Home, Inc., La Plata		ADDRESS Md.	

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WILLIAM COLE

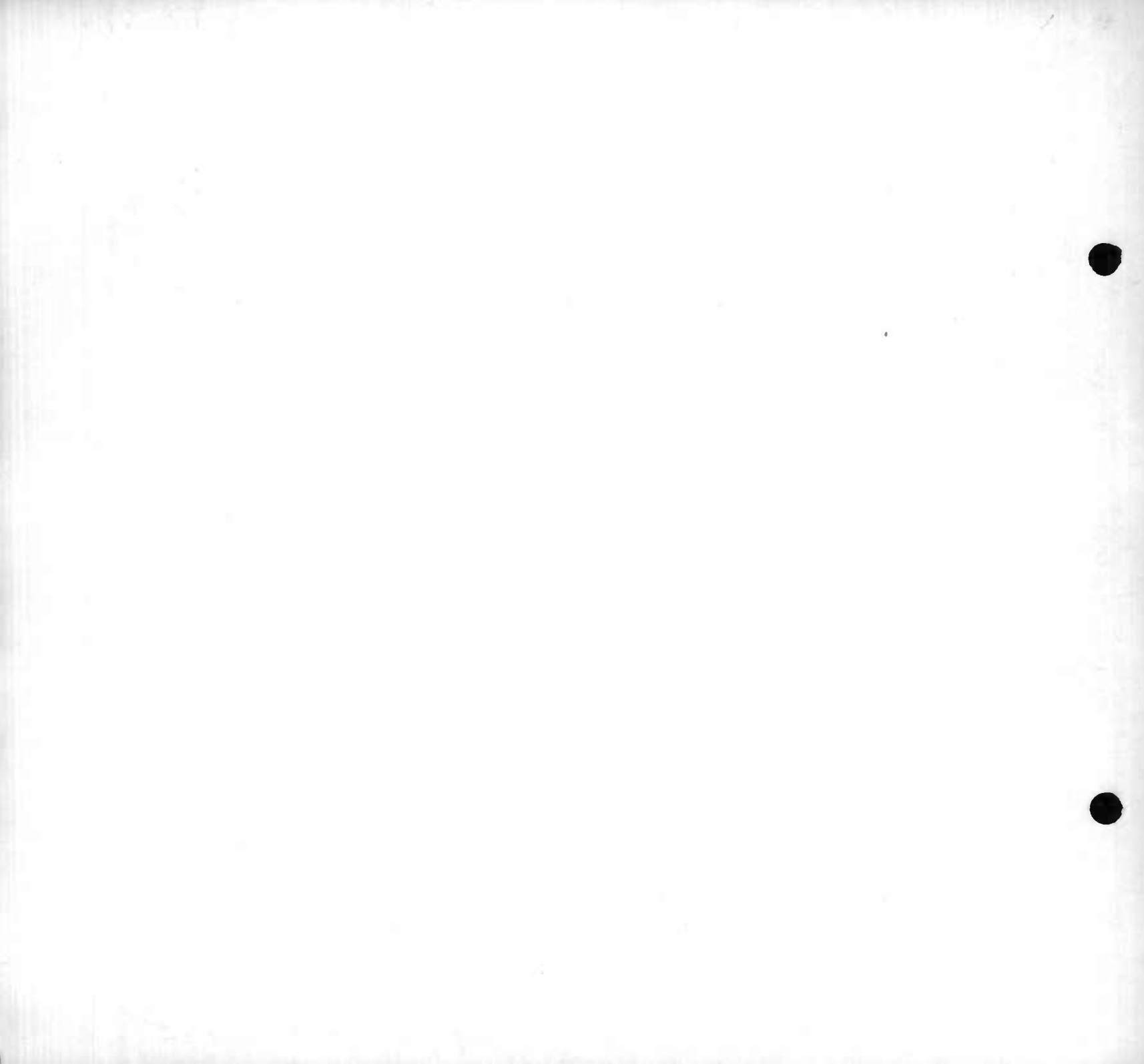
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MADE IN U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

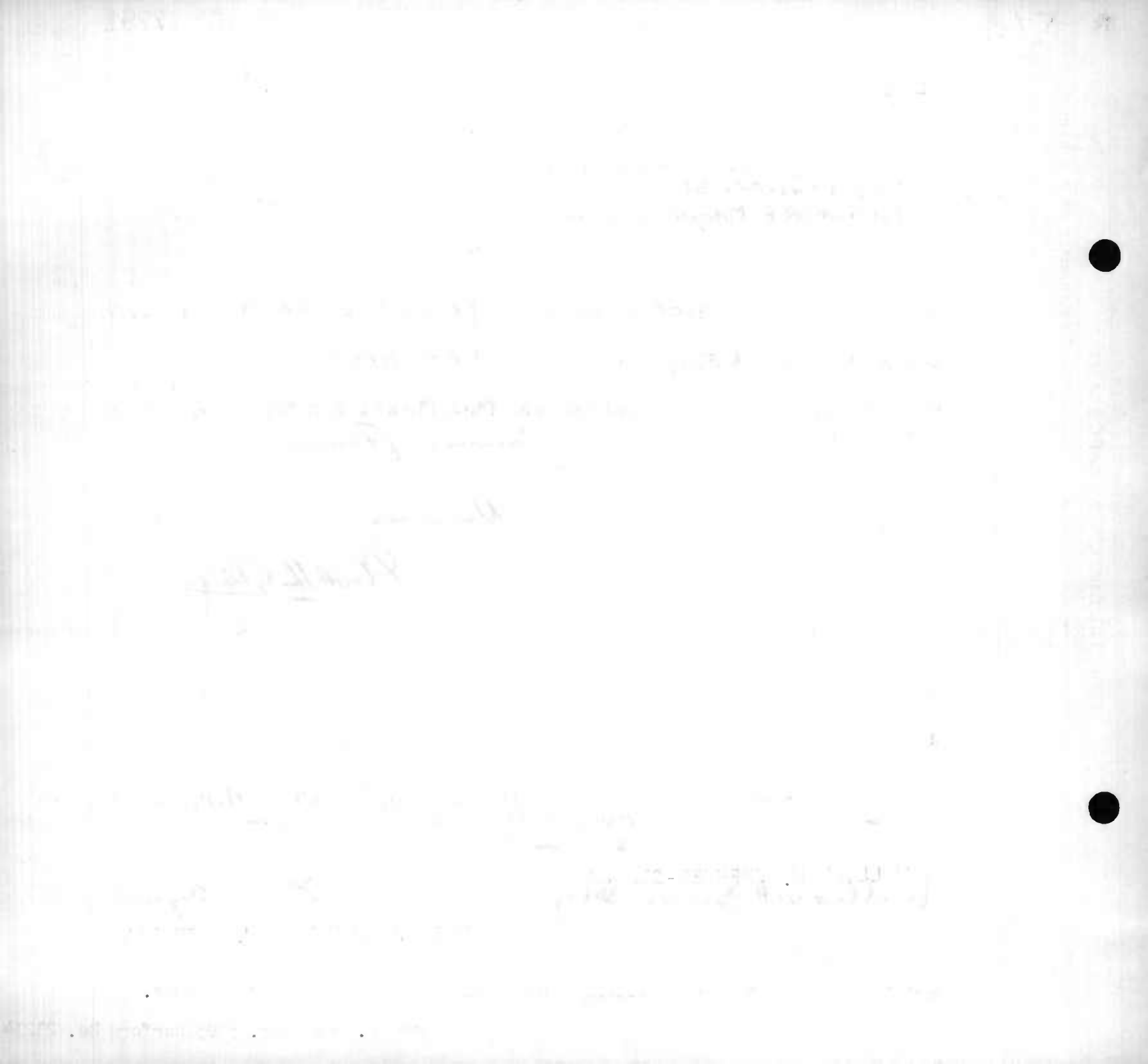
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7790	
BIRTH NO. 67 7790		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PARKER, Coley J.		2. DATE AND HOUR OF DEATH Aug 12, 1967 12⁰⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION S. BALTO. GEN. HOSP. H3		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write FULL and give township) BALTO. 25-04	
		D. STREET ADDRESS (If rural, give location) 3812 St. Victor St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1893	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Coast Guard		10B. KIND OF BUSINESS OR INDUSTRY MILITARY		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME LEWIS PARKER		14. MOTHER'S MAIDEN NAME VIRGINIA HART.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT MINNIE PARKER. ADDRESS Same.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) _____ DUE TO (C) 2 previous MI.		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/8 19 67 to 8/12 19 67 , that (I) (we) last saw the deceased alive on 8/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas H. Emory M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/12/67	
23C. PHYSICIAN'S NAME (Type) THOMAS H. EMORY		23D. ADDRESS 5B6A.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/67		24C. NAME OF CEMETERY OR CREMATORY Baltic Natl Cem. Baltimore Co	
24D. LOCATION (City, town, or county) (State) Md		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR A. E. F. F.	
25C. FUNERAL DIRECTOR Mc Gully F. H. 71725		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

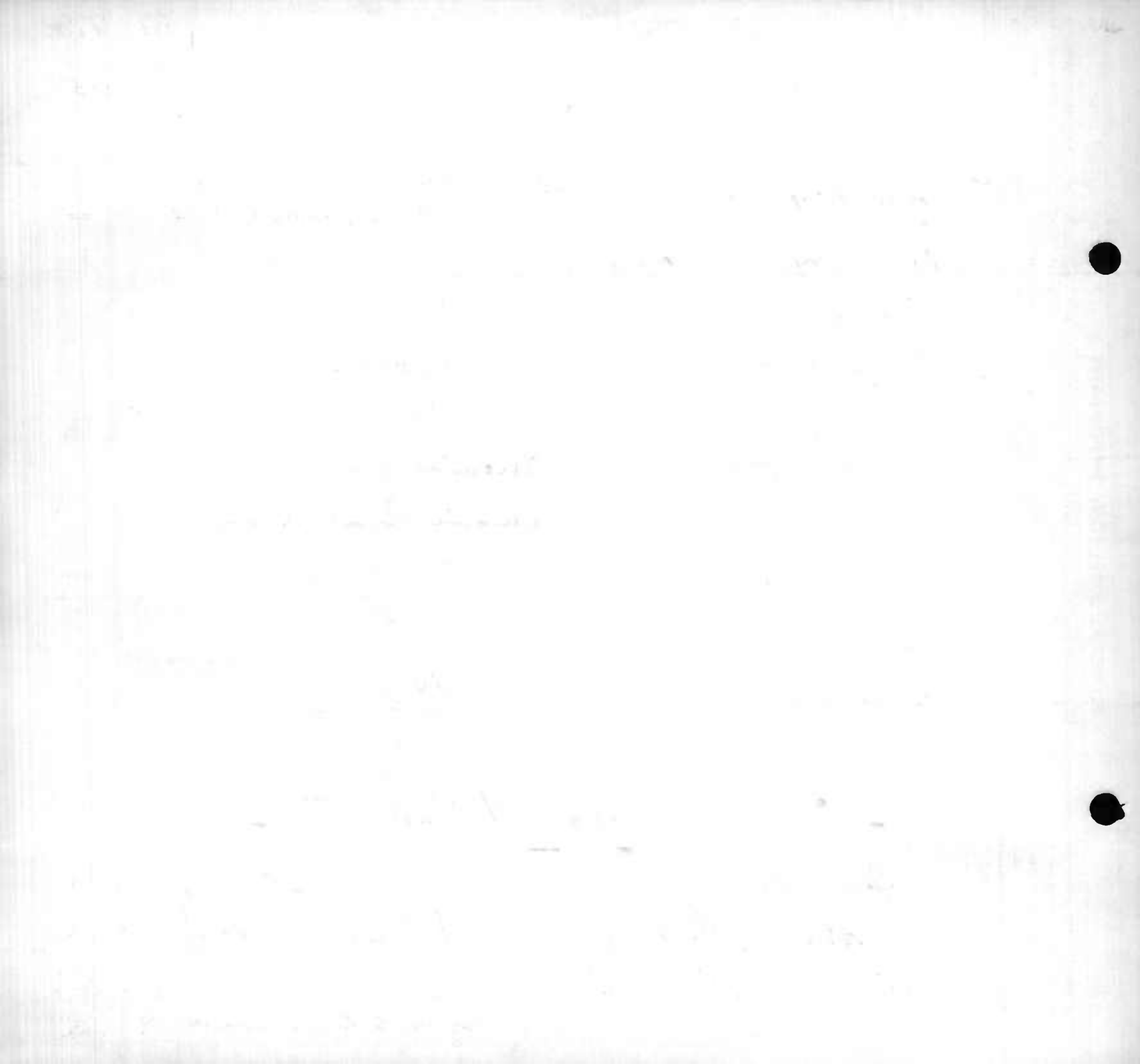
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7791	
BIRTH NO. 67 7791		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LLOYD JACOB KEMPER		2. DATE AND HOUR OF DEATH AUGUST 12, 1967 9:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE UNION MEMORIAL HOSPITAL 44 33rd + CALVERT ST. BALTIMORE MARYLAND 21215		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 12-06 102 WEST 27th STREET			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-18-04	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROOFER		10B. KIND OF BUSINESS OR INDUSTRY ROOF REPAIR		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JONATHAN KEMPER		14. MOTHER'S MAIDEN NAME ORA HAVERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mrs. MABEL H. KEMPER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 157X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Pancreas.		INTERVAL BETWEEN ONSET AND DEATH		ADDRESS 102 WEST 27th STREET	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Neumonia		(B) DUE TO Alcohol, Heavy Pains	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 11, 1967 to AUGUST 13, 1967 , that (I) (we) last saw the deceased alive on AUGUST 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE WILLIAM H. SPENCER-STRONG <i>William H. Spencer-Strong</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 12, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/67		24C. NAME of CEMETERY or CREMATORY Jacobus Evangelical	
24D. LOCATION (City, town, or county) (State) York County Penna.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7792</u>	
BIRTH NO. <u>67 7792</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HERMAN WEINSTEIN</u>		2. DATE AND HOUR OF DEATH <u>8/13/67</u> <u>10:15 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-19</u> D. STREET ADDRESS (If rural, give location) <u>4017 EMMART AVE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 1912</u>	9. AGE (In years lost birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RABBI</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
13. FATHER'S NAME <u>YEHSHUA</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>WIFE</u>	
				ADDRESS <u>SAME</u>	
18. <u>59281</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>Memia</u> (A) DUE TO <u>Chronic Renal Disease</u> (B) DUE TO (C) _____		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <u>8/12/1967</u> to <u>8/13/1967</u> , that (I) (we) last saw the deceased alive on <u>8/13/1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abe Levy</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ABE LEVY</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/14/1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Levin Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>New York</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1967</u>		25B. NAME OF REGISTRAR <u>Dr. W. E. Redman</u>		25C. FUNERAL DIRECTOR <u>Sprague & Lewis & Son, Inc</u>	
				ADDRESS <u>Garrison</u>	



FUNERAL DIRECTOR: IMPORTANT

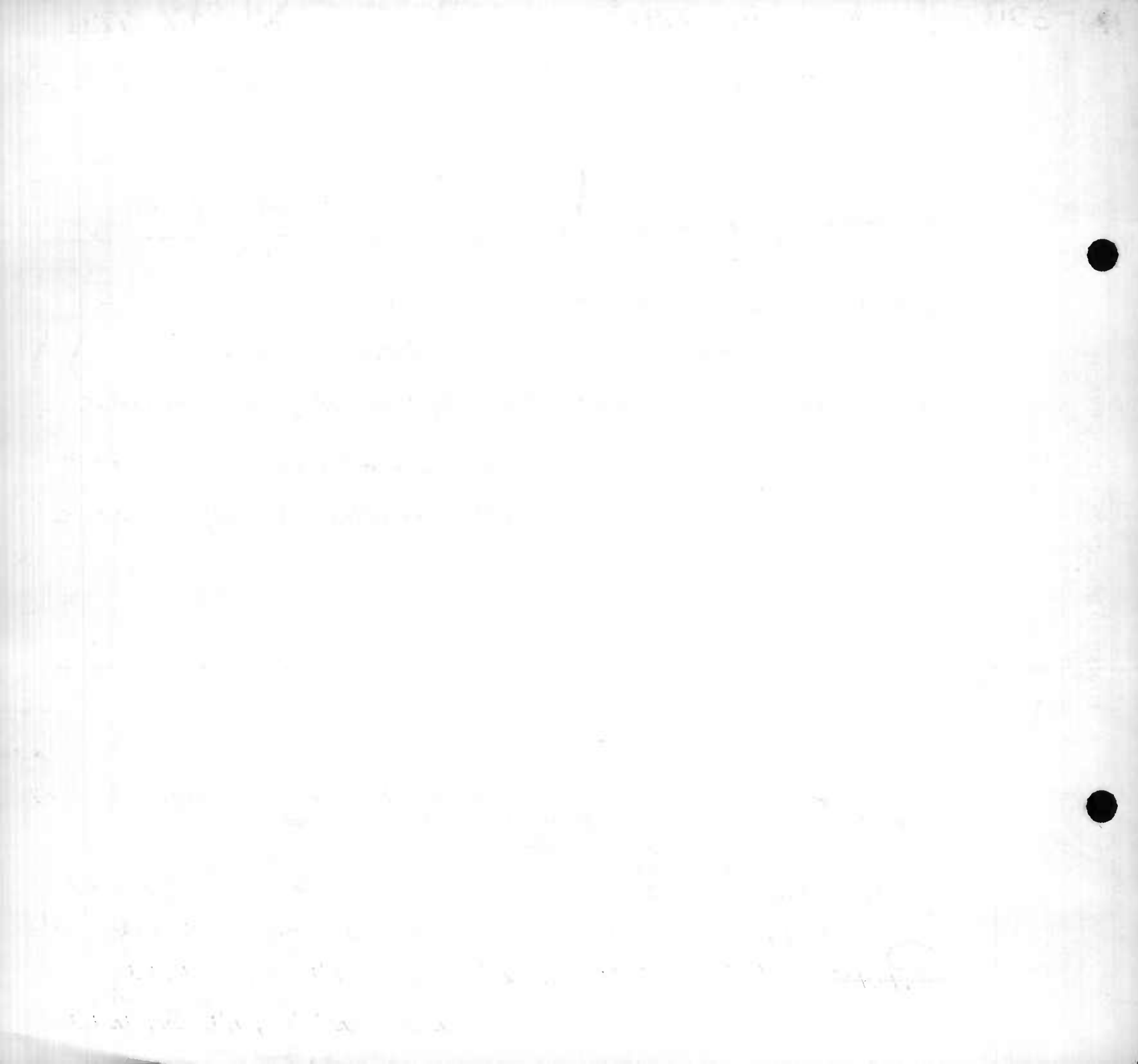
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7793				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7793	
M.E. CASE NO.				1. NAME OF DECEASED			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
YETTA CAPLAN				8/12/1967 1 3 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
SINAI HOSP				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 15-12			
				D. STREET ADDRESS (If rural, give location)			
				3833 ROLAND VIEW AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F	W	WIDOW	Dec 15, 1892	74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					RUSSIA		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ABRAHAM				IDA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No					MILTON CAPLAN		5606 JONGUIL
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X I				Myocardial Infarction		Instant	
ANTECEDENT CAUSES				(A) DUE TO		7 yr.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		7 yr.	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 22 1951 to 8/12 1967, that (I) (we) last saw the deceased alive on 8/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE LESTER N. KOLMAN, M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN, M.D.				23D. ADDRESS			
				3700 Park Heights Avenue 21215			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/14/1967		Anshe Emenah City Chaim Baita		Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1967		Rabbi E. Lasker		Sylvan S. Lasker, Inc		1000 Gorman, MD	

FUNERAL DIRECTOR: IMPORTANT

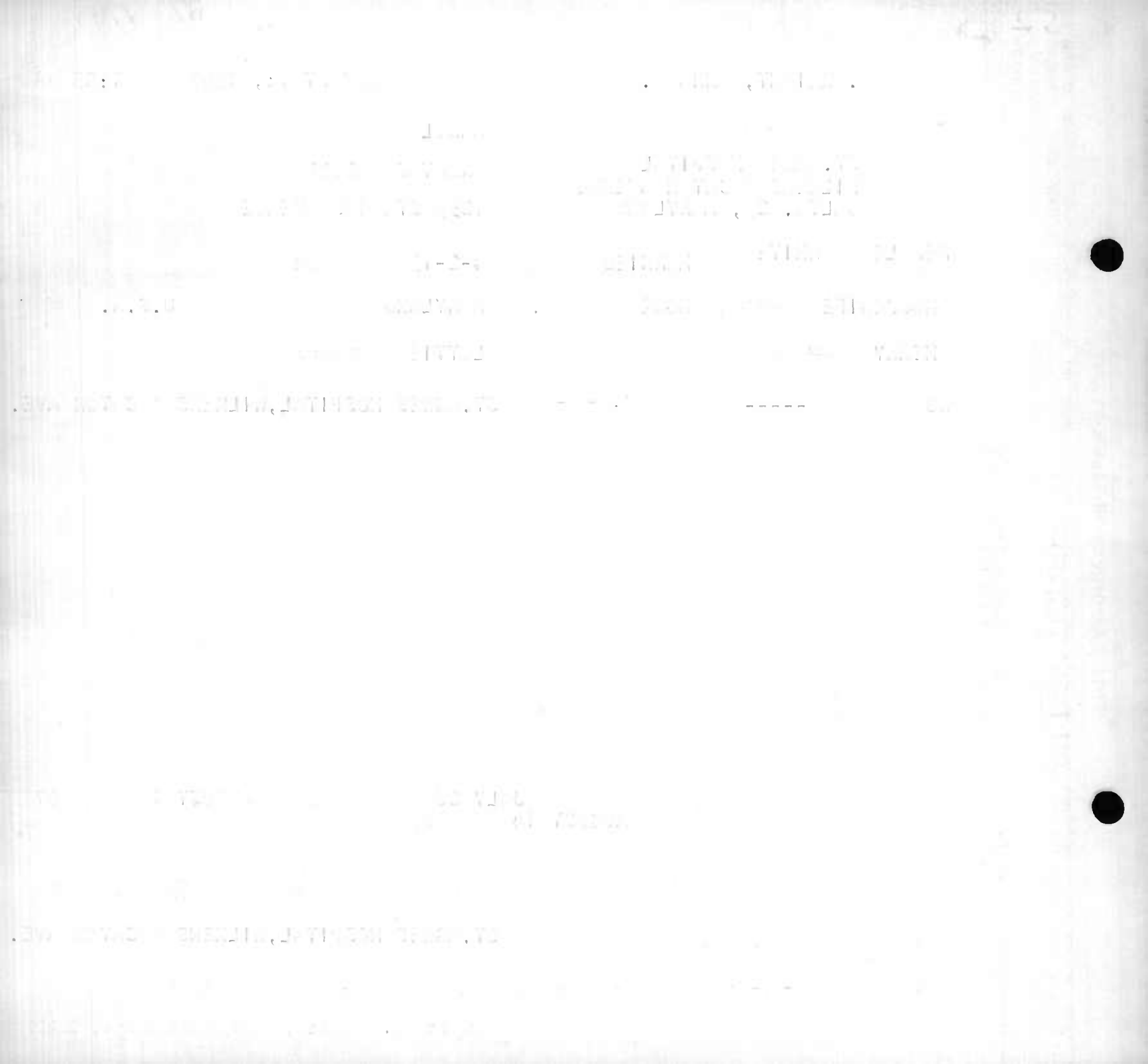
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7794	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 7794</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) HAROLD KENNETH WOOD</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 8-13-67 6⁰⁰ 1⁰⁰ A.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US PUBLIC HEALTH SERVICE HOSP. WYMAN PARK DRIVE BALTIMORE, Md. </p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VA. B. COUNTY V-43 </p>		
<p>5. SEX M</p>		<p>6. RACE W</p>		<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Health Advisor </p>		<p>10B. KIND OF BUSINESS OR INDUSTRY US PHS </p>		<p>8. DATE OF BIRTH 9-16-13 </p>	
<p>13. FATHER'S NAME John Wood </p>		<p>14. MOTHER'S MAIDEN NAME GRACE HAND </p>		<p>9. AGE (In years lost birthday) 53</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES USN 1942-1946 </p>		<p>16. SOCIAL SECURITY NO. 355-03-334-5 </p>		<p>17. INFORMANT ADDRESS USPHS Hospital Records </p>	
<p>18. 163X1 CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) CARCINOMATOSIS DUE TO</p> <p>(B) ADENOCARCINOMA of Lung DUE TO</p> <p>(C) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH WEEKS months </p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION 2 </p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) YES </p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> </p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that the (this hospital) attended the deceased from Aug. 7 19 67 to Aug. 13 19 67, that the (we) last saw the deceased alive on Aug 13 19 67 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE William L. Wilkie M.D. </p>				<p>23B. DATE SIGNED 8/13-67 </p>	
<p>23C. PHYSICIAN'S NAME (Type) William L. WILKIE </p>		<p>23D. ADDRESS US PHS Hospital, Baltimore, Md. </p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Aug 17, 1967 </p>		<p>24B. DATE 8/17/67 </p>		<p>24C. NAME OF CEMETERY or CREMATORY Columbia Gardens Cemetery </p>	
<p>24D. LOCATION (City, town, or county) (State) Arlington, Virginia </p>		<p>25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967 </p>			
<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D. </p>		<p>25C. FUNERAL DIRECTOR Robert J. Murphy </p>			
<p>25D. ADDRESS Murphy Funeral Home, Arlington, Virginia </p>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7795				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7795	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				. KNIGHT, ANNA A.		AUGUST 14, 1967 1:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MARYLAND				A. STATE MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) ARBUTUS 21227			
				D. STREET ADDRESS (If rural, give location) 1239 STEVENS AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 4-2-13	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY Krabbe				14. MOTHER'S MAIDEN NAME LOTTIE Dresbach			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-36-6306		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
18. 190.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MEASTATIC MALIGNANT MELANOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 26 19 67 to AUGUST 14 19 67 , that (I) (we) last saw the deceased alive on AUGUST 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. M. Revilla</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-14-67	
23C. PHYSICIAN'S NAME (Type) R. M. Revilla				23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave, 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7796	
BIRTH NO. 67 7796		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jacob JACOB B J OTTENHEIMER		2. DATE AND HOUR OF DEATH 8-10-67 6:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY MD			
FULL NAME OF HOSPITAL OR INSTITUTION Thim Memorial Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-20	
		D. STREET ADDRESS (If rural, give location) 3600 Labyrinth Road, Apt. D21			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-25-95	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) MD BALTIMORE, MD.	
13. FATHER'S NAME OTTENHEIMER, BERNARD M.		14. MOTHER'S MAIDEN NAME Alice B. Brown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. 1 ARMY		16. SOCIAL SECURITY NO. 215-05-4952		17. INFORMANT Mrs. Phyllis Ottenheimer, 3600 Labyrinth Road Apt. D21	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 151X I		CAUSE OF DEATH (A) Carcinoma Gastric DUE TO (B) Pulmonary with pulmonary infection DUE TO (C) Prob. Cerebral.		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/23/67 to 8/10/67 that (I) (we) last saw the deceased alive on 6:40 8/10/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. S. Stanley		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/10/67	
23C. PHYSICIAN'S NAME (Type) G. S. STANLEY		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Stanley		25C. FUNERAL DIRECTOR, ADDRESS Sol Levinson & Bros. Inc., 6010 Reist., Rd.	

2

Chief, Special Agent

M W Macario

Residence

See telephone call

1-28-92

Black (brown)

Castro
Castro
Castro

P. 40

8/10/84

8/10

~~8/10/84~~

X

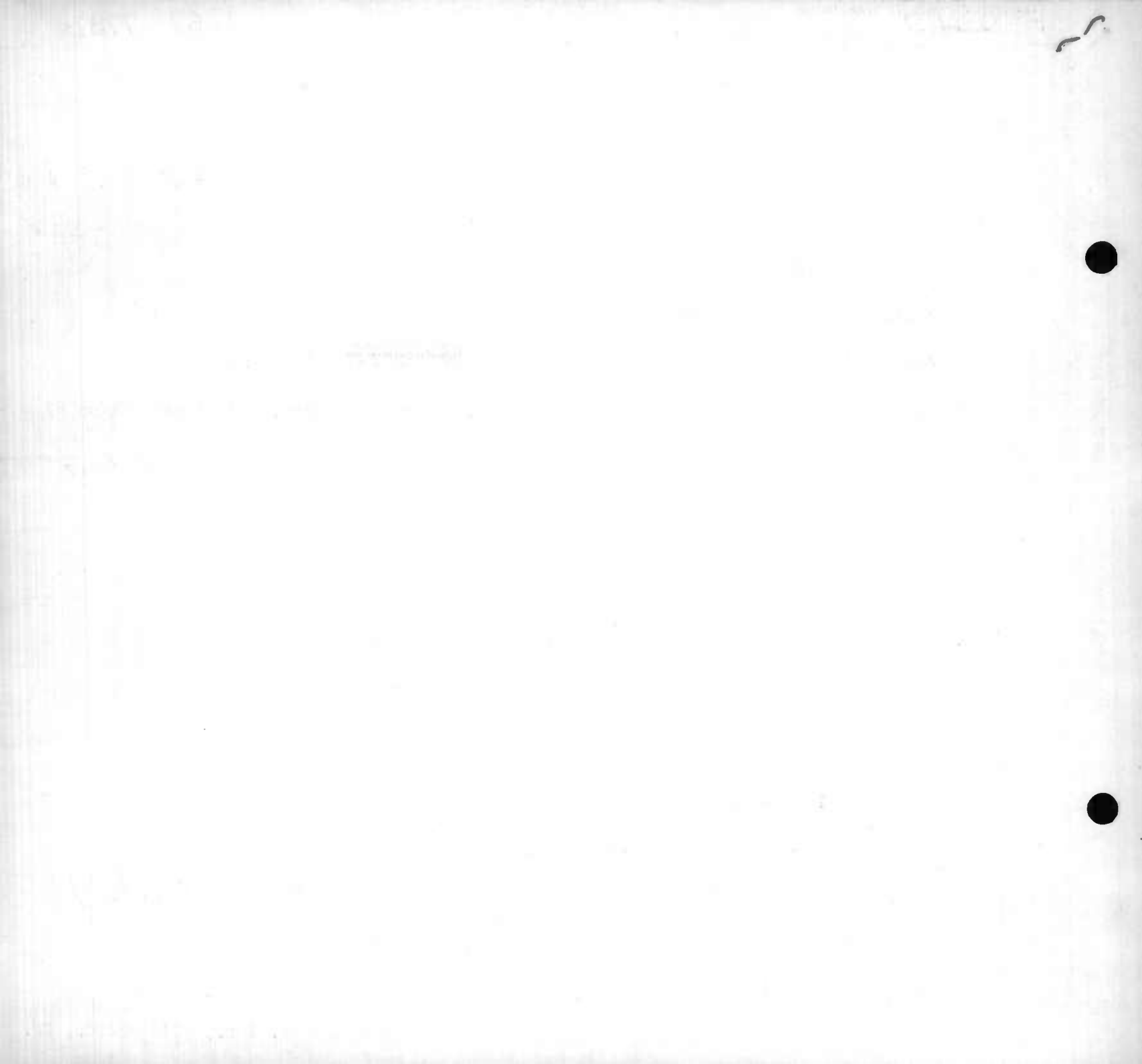
8/10/84

RECORDS SECTION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

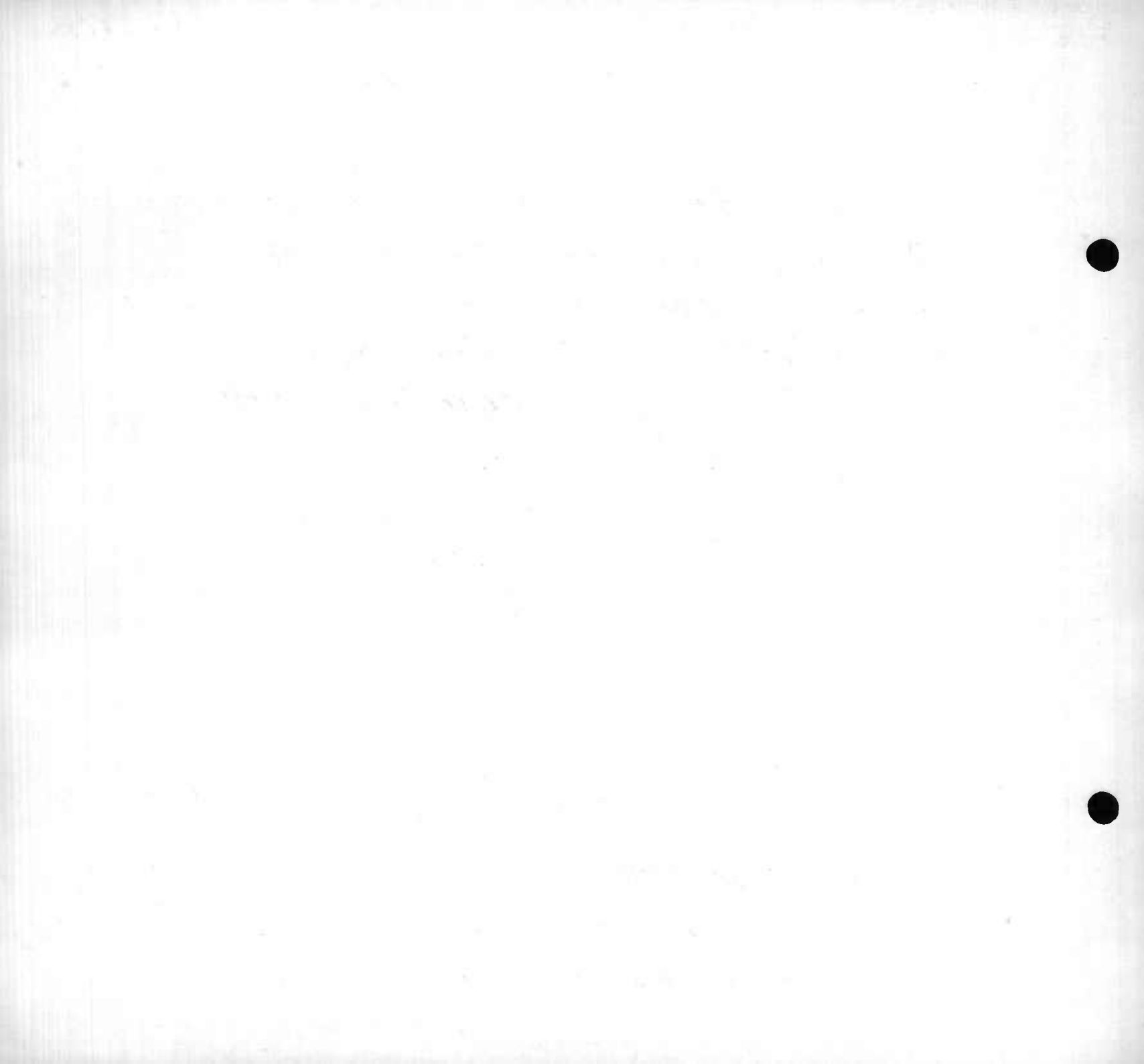
Baltimore City Health Department				Registered No. 67 7797	
<div style="display: flex; justify-content: space-between;"> F-12432 67 7797 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <i>Fannie Feigelson</i>			2. DATE AND HOUR OF DEATH <i>8/10/67</i> <i>4:05 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>28-31</i> D. STREET ADDRESS (If rural, give location) <i>4104 Rockfield Avenue</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>March 21, 1892</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Latvia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Abraham Gassel</i>		
14. MOTHER'S MAIDEN NAME <i>Fruma Reva</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>UNKNOWN</i>			17. INFORMANT <i>Mr. Robert Feigelson, 6413 Laurel Drive #7</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>05344/1967</i> <i>irreversible shock</i>			INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Septicemia</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cancer of Bone of Hip</i>					
19A. DATE OF OPERATION <i>2</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <i>Dr. (this hospital)</i> attended the deceased from <i>July 4</i> <i>1967</i> to <i>Aug 10</i> <i>1967</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>Aug 10</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Marc Lowen</i>			23B. DATE SIGNED <i>8/10/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Marc Lowen</i>			23D. ADDRESS <i>Sinai Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/13/67</i>	24C. NAME of CEMETERY or CREMATORY <i>Chizuk Amuno (Arlington)</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Feigelson</i>	25C. FUNERAL DIRECTOR <i>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7798	
CERTIFICATE OF DEATH					
BIRTH NO. 67 7798		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) NORMAN O'PHER			2. DATE AND HOUR OF DEATH AUG 13 - 1967 8:35 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE MD B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
BALTIMORE			703 N. APPLETON ST		
5. SEX M	6. RACE COI	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH JUNE 27-1888	9. AGE (In years, most birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RET. LABORER		SCRAP METAL CO	MADISON MD		U.S.A.
13. FATHER'S NAME JOHN W. O'PHER			14. MOTHER'S MAIDEN NAME JENNIE STANLEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-5905	17. INFORMANT ADDRESS ALLEAN DAVIS 703 N. APPLETON ST		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X		Respiratory failure			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerotic C.V.R.			
DUE TO		Dissect			
DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/7/67 to 8/13/67 that (I) (we) last saw the deceased alive on 8/7/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Borofsky M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) S. Borofsky M.D.				23D. ADDRESS 601 N. Mount St Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 8/16/67		24C. NAME OF CEMETERY or CREMATORY MALONES CHAPEL	
				24D. LOCATION (City, town, or county) (State) MADISON MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Wardman Bldg 638 N. Gilman St	



W-450

67 7799

BALTIMORE CITY HEALTH DEPARTMENT

67 7799

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOMER R. WOOLWINE

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1967 8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1615 St. Paul Street
8-21-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1615 St. Paul Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Sept. 19, 1920

9. AGE (In years
last birthday)

47 46

If Under 1 Yr. II Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UNEMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

WELFARE

11. BIRTHPLACE (State or foreign country)

Montgomery Co., Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNEMPLOYED Noah Woolwine

14. MOTHER'S MAIDEN NAME

UNEMPLOYED Essie Spradlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

UNEMPLOYED

ADDRESS

Edgar Woolwine, Christiansburg, Va.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Laennec's cirrhosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

—

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/67

23C. NAME OF CEMETERY or CREMATORY

Family Cem. County
Christiansburg, Va.

23D. LOCATION

(City, town, or county) (State)
Christiansburg Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

Charles E. Fagley, M.D.

24C. FUNERAL DIRECTOR

Mrs. E. Fisher

1930 Eastern Ave.

V.S. 153

8-21-67

M.H.

R-265

67 7800 BALTIMORE CITY HEALTH DEPARTMENT

67 7800

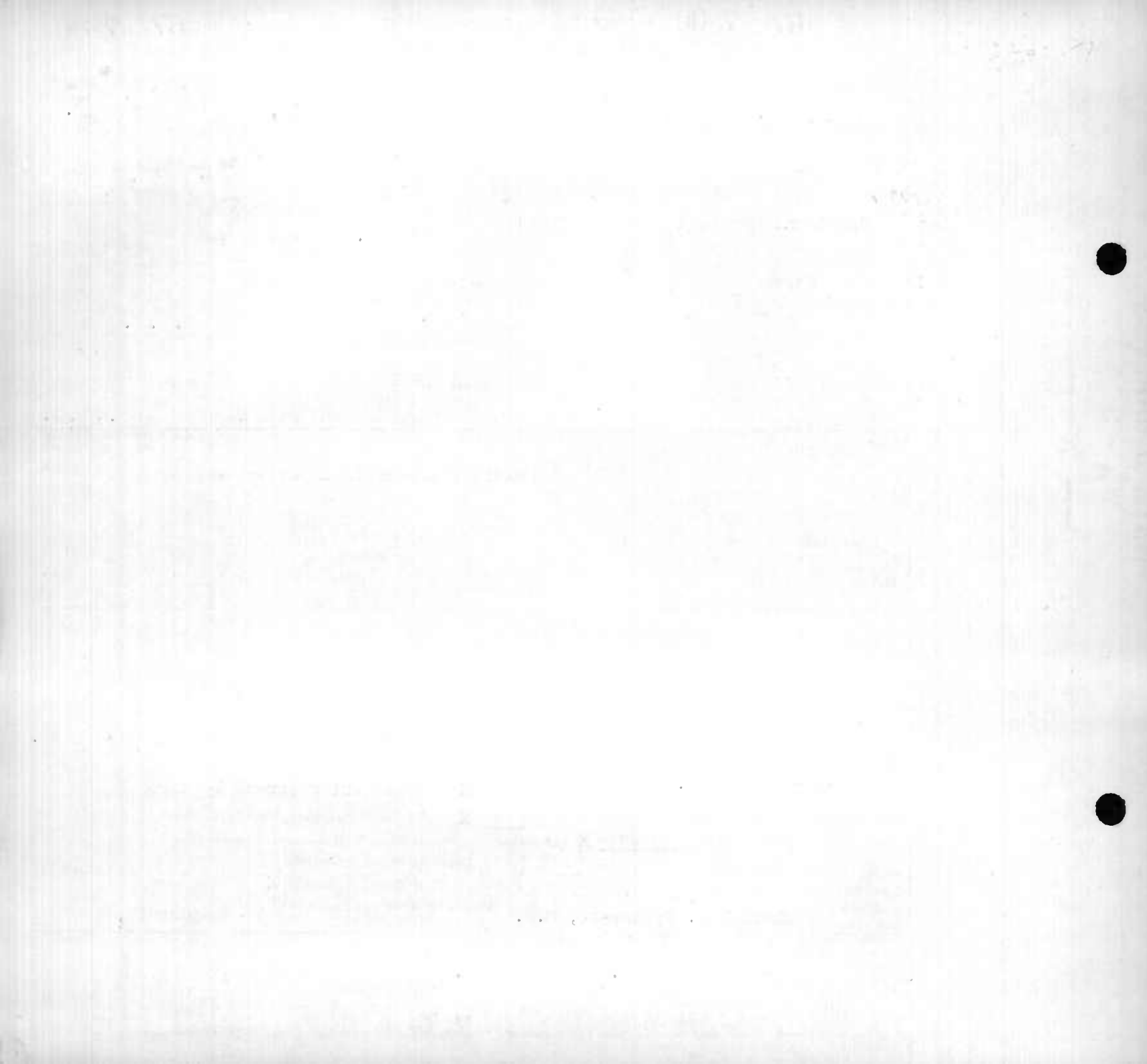
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (Jam) JAMES RICHARDSON		2. DATE AND HOUR PRONOUNCED DEAD August 11, 1967 9:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 99 Provident Hospital (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02 D. STREET ADDRESS (If rural, give location) 1131 N. Fremont Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 6-5-04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 63 If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Richardson		14. MOTHER'S MAIDEN NAME Willie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sylvania Richardson		ADDRESS 8 Howard St., S.C.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fremont Avenue north of Winchester St.		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 8-11-67 8:30 P.	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 16-01	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 12, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-16-67	
23C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		24B. NAME OF REGISTRAR Robert E. Finkbeiner	
24C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

N869.2



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

HARRY

MORGAN

2. DATE AND HOUR PRONOUNCED DEAD

August 10, 1967

3:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1007 W. Lexington St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1007 W. Lexington Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/22/1892

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dinwiddie Co. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

General Morgan

14. MOTHER'S MAIDEN NAME

Luvenia Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

224-14-4856

17. INFORMANT

ADDRESS

Annie Morgan 1007W. Lexington St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Stomach
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 15, 1967

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION (City, town, or county) (State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

R. E. E. F. F.

24C. FUNERAL DIRECTOR

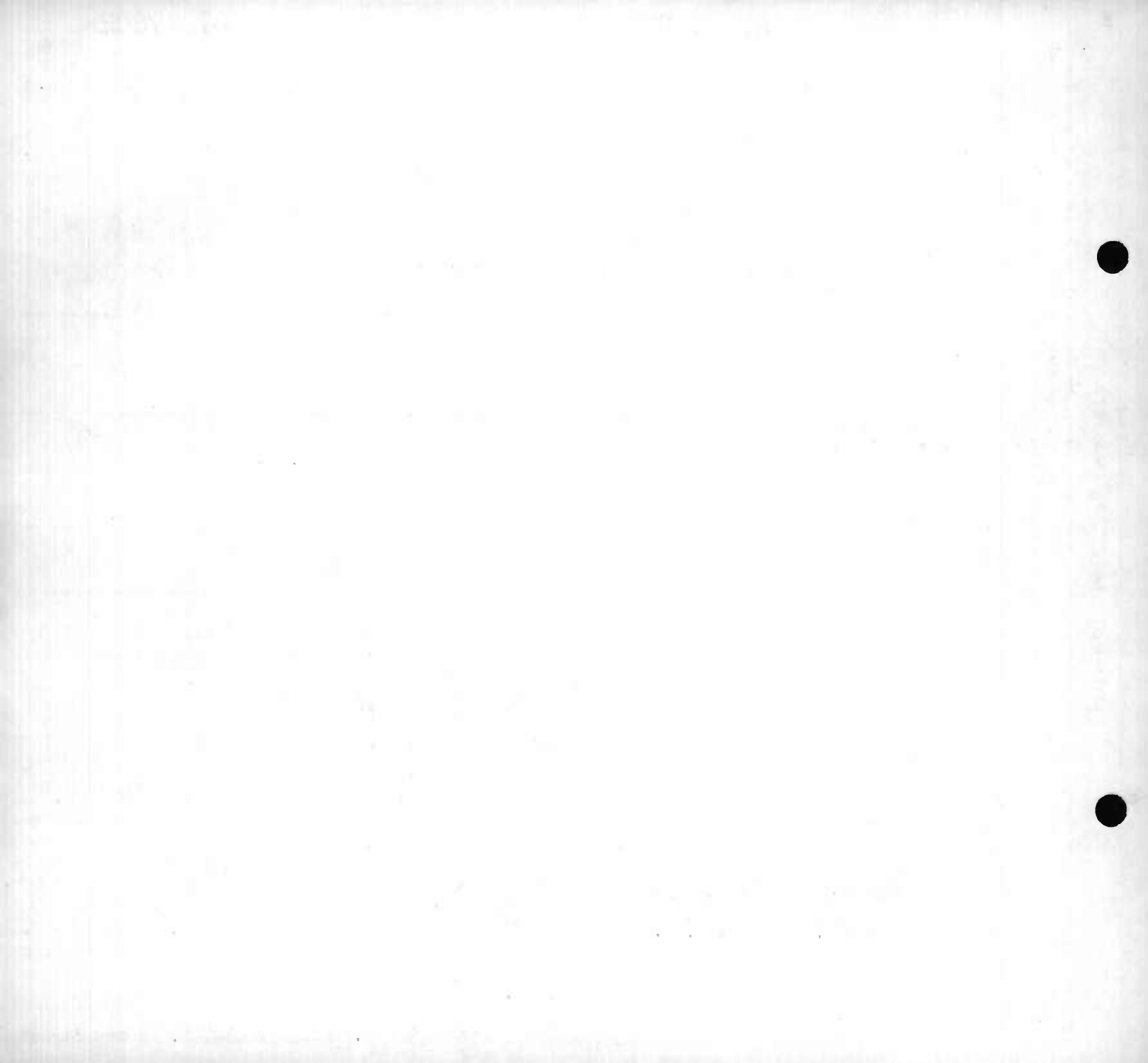
Williams Funeral Home 3199 Schuylkill St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7802				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7802	
1. NAME OF DECEASED (Type or Print) Sallie Fernandez				2. DATE AND HOUR OF DEATH August 11, 1967 7:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2444 Shirley Avenue Baltimore, Maryland 21215				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2444 Shirley Avenue			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 3, 1903	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Allen				14. MOTHER'S MAIDEN NAME Sarah Lewis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-3044		17. INFORMANT John Ashby 2444 Shirley Avenue			
18. 157X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the Stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease.				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1, 1967 to August 11, 1967 , that (I) (we) last saw the deceased alive on Aug. 2, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Morton M. Krieger				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug. 12, 1967	
23C. PHYSICIAN'S NAME (Type) Morton M. Krieger, M. D.				23D. ADDRESS 615 Hammonds Lane Baltimore, Maryland 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR John S. Phillips		25C. FUNERAL DIRECTOR ADDRESS 1727 N. Monroe Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 7803		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7803	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				HOPE, (SR.) DANIEL	
2. DATE AND HOUR OF DEATH		AUGUST 10, 1967 10:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
ST. AGNES HOSPITAL		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND 21210			
WILKENS & CATON AVES.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTIMORE, MD. 21229		BALTIMORE			
40		D. STREET ADDRESS (If rural, give location)			
		501 W. UNIVERSITY PARKWAY			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
MALE	WHITE	MARRIED	08-25-88	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Owner		Wholesale Hardware	MARYLAND		YES USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CLIFTON Hope DEC'D			ELIZABETH (HARRISON) DEC'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
UNKNOWN		21201-1104	WILKENS & CATON AVES. ST. AGNES RECORDS BALTIMORE, MD. 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		Cardiogenic Shock 2 hr			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		Acute Myocardial Infarction 1 day			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 8-10-1967 to 8-10-1967, that (X) (we) last saw the deceased alive on 8-10-1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Raymond D. Bahr M.D.				8/9/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RAYMOND D. BAHR M.D.				WILKENS & CATON ST. AGNES HOSPITAL - BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/14/67		Lorraine Park Mausoleum Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 15 1967		R. E. Fisher, Jr.		Wm. Fickner, Jr. 1401 E. Pratt St. Baltimore, Md.	

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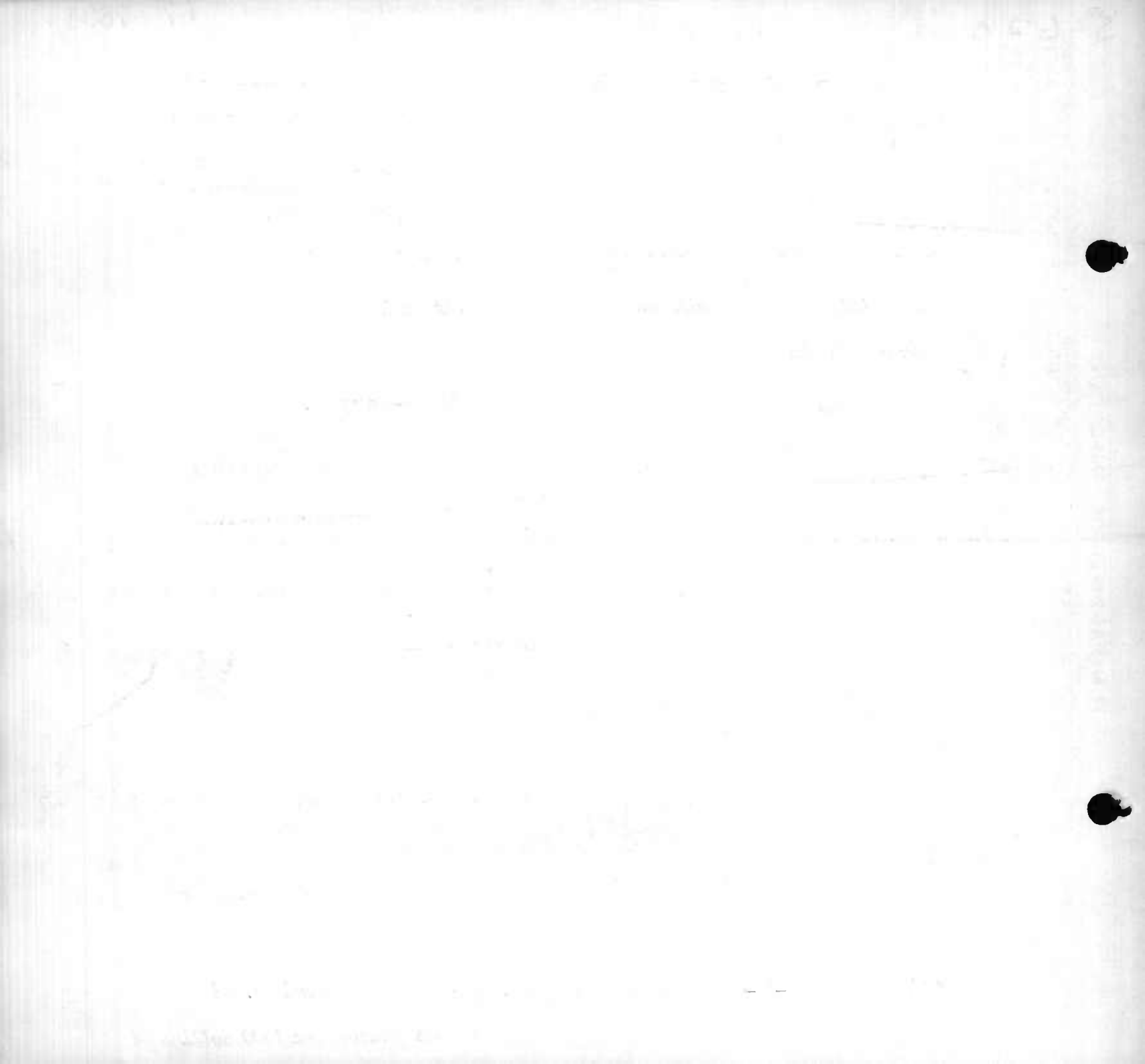
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. M.E. CASE NO.		67 7804		67 7804	
1. NAME OF DECEASED (Type or Print) Anthony J. Saroka Sr			2. DATE AND HOUR OF DEATH 8-13-67---10:50 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND St. Agnes Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore City		
5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1514 Hollins St.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Railroad		8. DATE OF BIRTH 12-15-83	
				9. AGE (In years last birthday) 83	
				If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME Samuel Saroka			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wife-Mary K.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4201 I		CAUSE OF DEATH (A) CARDIOVASCULAR COLLAPSE DUE TO (B) ARTERIOSCLEROTIC CARDIAC DISEASE WITH HX OF MYOCARDIAL INFARCTIONS WITH VENTRICULAR ANEURYSM		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9:11 PM 8/13 1967 to 10:50 PM 8/13 1967 , that (I) (we) last saw the deceased alive on 8/13 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE W. E. Signor M.D.				23B. DATE SIGNED 8/13/67	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-67		24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Howard Co. Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR R. E. Taylor M.D.		25C. FUNERAL DIRECTOR Thomas J. Kenny, Inc 1600 Hollins St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7805</u>	
BIRTH NO. <u>67 7805</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>THOMAS STAIGER</u>		2. DATE AND HOUR OF DEATH <u>August 13, 1967</u> <u>7:45 p. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bou Secours Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21-02</u>			
		D. STREET ADDRESS (If rural, give location) <u>1221 Carroll Street</u>			
5. SEX <u>M</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-22-96</u>	9. AGE (In years lost birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coke Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore N.Y.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Staiger</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MICHAEL STAIGER-1221 Carroll St.</u>	
18. <u>465X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute Pulmonary embolism</u> DUE TO <u>Acute pulm. embolism</u> (B) <u>?</u> DUE TO (C) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>?</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>?</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>?</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>?</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>August 12</u> 19 <u>67</u> to <u>August 13</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>August 13</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>abraham</u>				23B. DATE SIGNED <u>8/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR A. BRAVO</u>				23D. ADDRESS <u>Bou Secours Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/13/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1967</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor, MA</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc Baltimore</u>			



39-13-16

W-452 67 7806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 7806

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)(Mamie Williams)
WILLIAMS, MAMIE

2. DATE AND HOUR OF DEATH

13 AUGUST 1967 3:07 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4940 EASTERN AVENUE 21224

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED

8. DATE OF BIRTH

2-16-07

9. AGE (In years
lost birthday)
60If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MISSISSIPPI

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ADAM

Anderson

14. MOTHER'S MAIDEN NAME

MINNIE ?

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

212

16. SOCIAL
SECURITY NO.

16 5878

17. INFORMANT
Mr Robert Williams 4501 Wilshire Ave.

RECORDS-BCN-4940 EASTERN AVENUE- 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) GRAM NEGATIVE SEPTICEMIA

DUE TO

3ds

(B) CHRONIC URINARY TRACT INFECTION 12 YRS.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MULTIPLE SCLEROSIS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 2-4-19 66 to 8-13-19 67
that (1) (we) last saw the deceased alive on 13 AUGUST 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Russell D Hicks

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

13 AUGUST 1967

23C. PHYSICIAN'S
NAME (Type)

Russell D. Hicks

M.D.

23D. ADDRESS

4940 EASTERN AVE. BALTIMORE MD 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/17/67

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Henry Sander & Sons Inc.

ADDRESS

Baltimore Maryland 21213

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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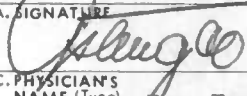
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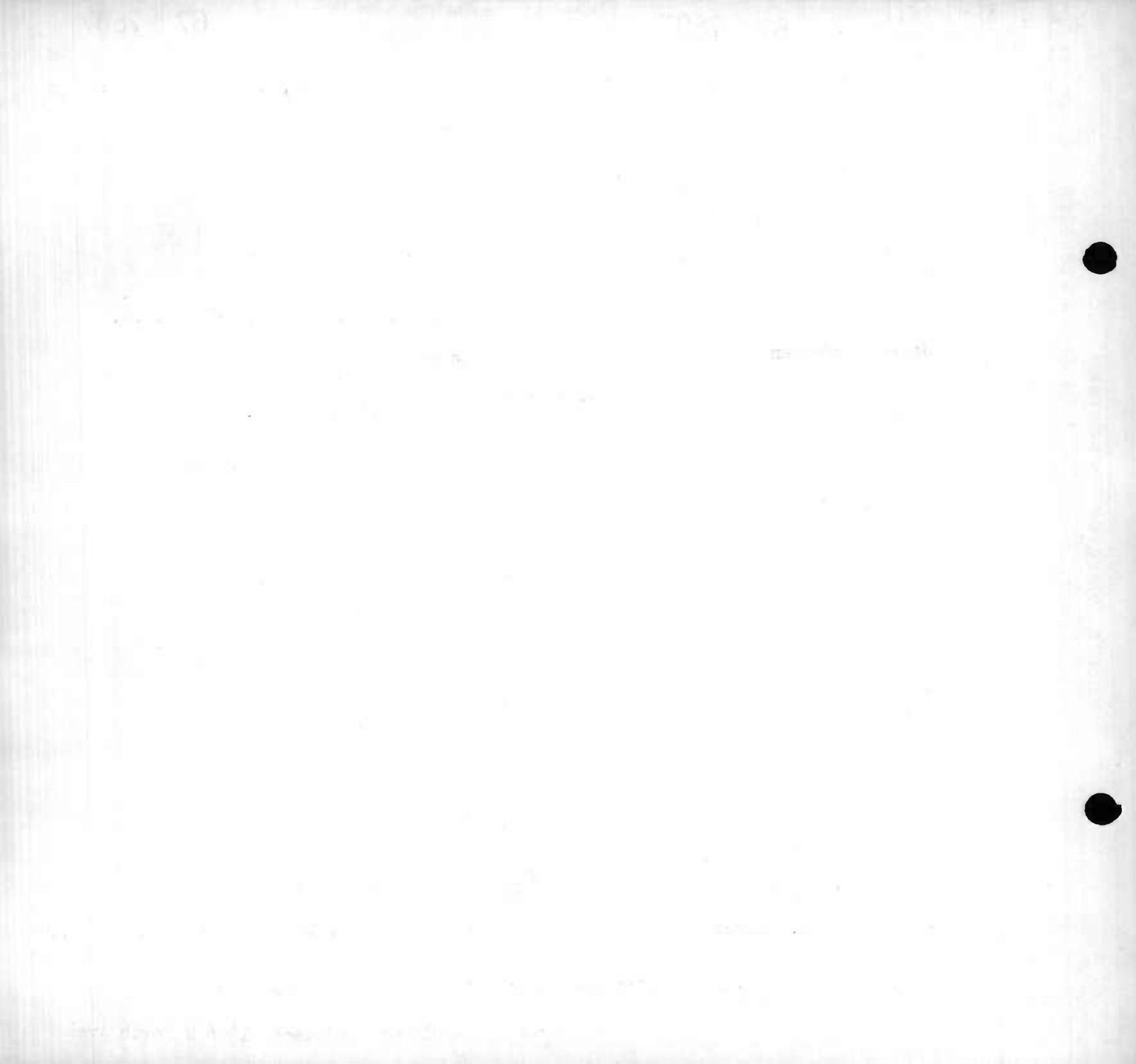
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

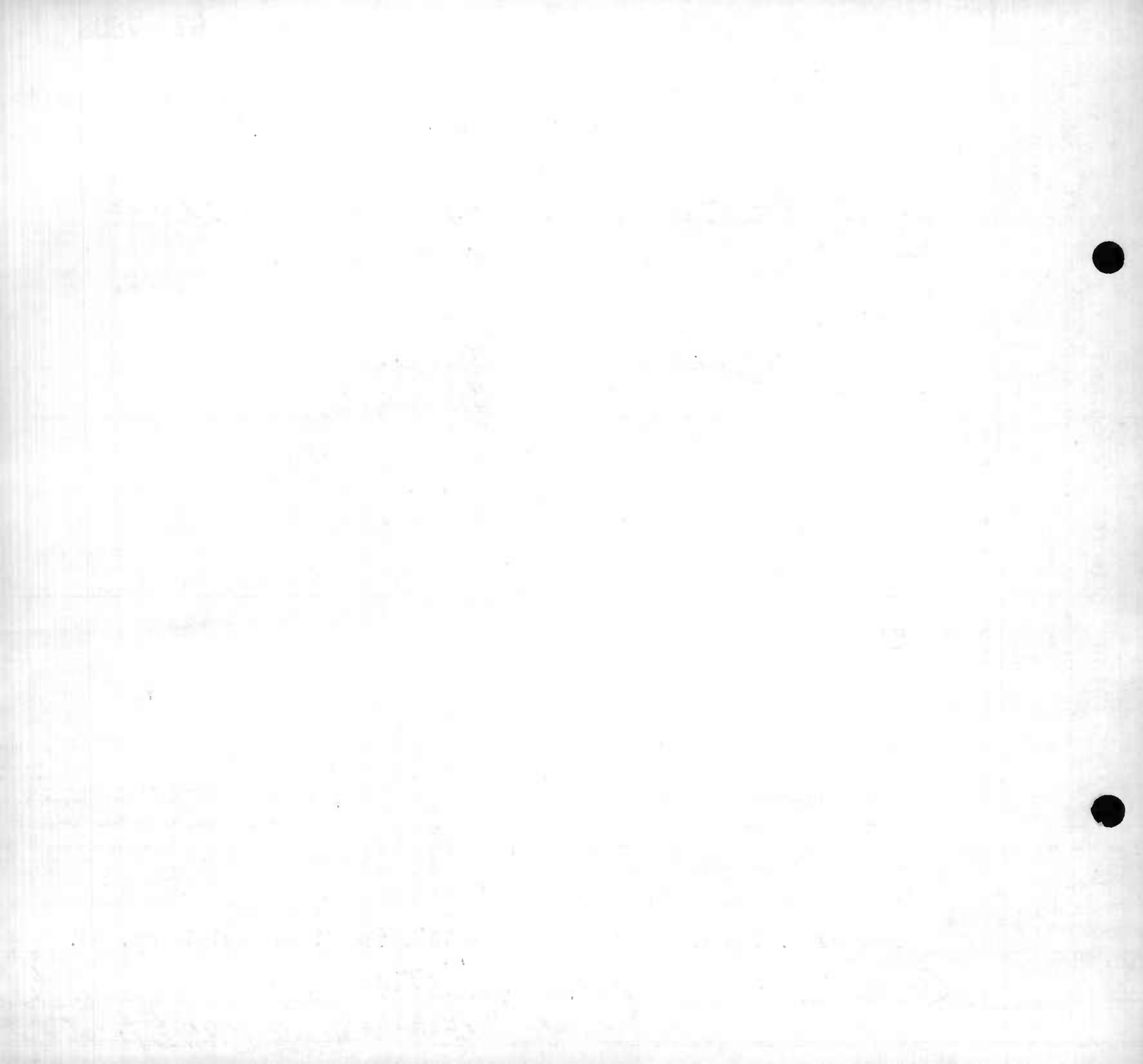
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7807	
BIRTH NO. 67 7807		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Virginia Davis (McFadden)		2. DATE AND HOUR OF DEATH August 13, 1967 6:50 pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 10-01			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Inc. 1514 Division Street Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 504 Eager Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/27/27	9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania U.S.A.	
13. FATHER'S NAME James McFadden		14. MOTHER'S MAIDEN NAME Laura		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 182-24-7414		17. INFORMANT ADDRESS Robert Davis (hus) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Malignant Hypertension Renal Failure		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 8, 1967 to August 13, 1967 and that (I) (we) last saw the deceased alive on August 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Dr. Tengco				23B. DATE SIGNED M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23D. ADDRESS M.D. Provident Hosp. 1514 Division St. Balto., Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/67		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																													
BIRTH NO. 67 7808					CERTIFICATE OF DEATH					Registered No. 67 7808																			
M.E. CASE NO.										1. NAME OF DECEASED (Type or Print) <i>Ratie Henderson</i>										2. DATE AND HOUR OF DEATH <i>8-8-1967</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE <i>Maryland</i> B. COUNTY <i>12-23</i>																			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>										D. STREET ADDRESS (If rural, give location) <i>2460 Brentwood Ave</i>																			
5. SEX <i>F</i> 6. RACE <i>Col</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>										8. DATE OF BIRTH <i>5-30-93</i> 9. AGE (In years last birthday) <i>74</i>																			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>										10B. KIND OF BUSINESS OR INDUSTRY																			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>										12. CITIZEN OF WHAT COUNTRY?																			
13. FATHER'S NAME <i>John Squirrel</i>										14. MOTHER'S MAIDEN NAME <i>Florence Cook</i>																			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.																			
17. INFORMANT <i>Florence Goodman</i>										ADDRESS																			
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH																			
ANTECEDENT CAUSES										INTERVAL BETWEEN ONSET AND DEATH																			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) <i>Coronary Occlusion</i> <i>1 day</i>																			
										(B) <i>Arteriosclerosis</i> <i>years</i>																			
										(C) <i>Diabetes Mellitus</i> <i>years</i>																			
II																													
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																													
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED																			
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)																			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																													
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)										21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>																			
21F. HOW DID INJURY OCCUR?																													
22. I certify that (I) (this hospital) attended the deceased from <i>1962</i> 19 <i>8/8/1</i> to <i>1967</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/1</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																													
23A. SIGNATURE <i>Charles R. Venter</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED <i>8/10/67</i>																			
23C. PHYSICIAN'S NAME (Type) <i>Charles R. Venter</i>										23D. ADDRESS <i>2320 Eutaw Place Baltimore, Md.</i>																			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>										24B. DATE <i>8-12-67</i>																			
24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn Em Balto</i>										24D. LOCATION (City, town, or county) (State) <i>Md</i>																			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1967</i>										25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>																			
25C. FUNERAL DIRECTOR <i>Raymer Sanders</i>										ADDRESS <i>217 E. Preston St</i>																			



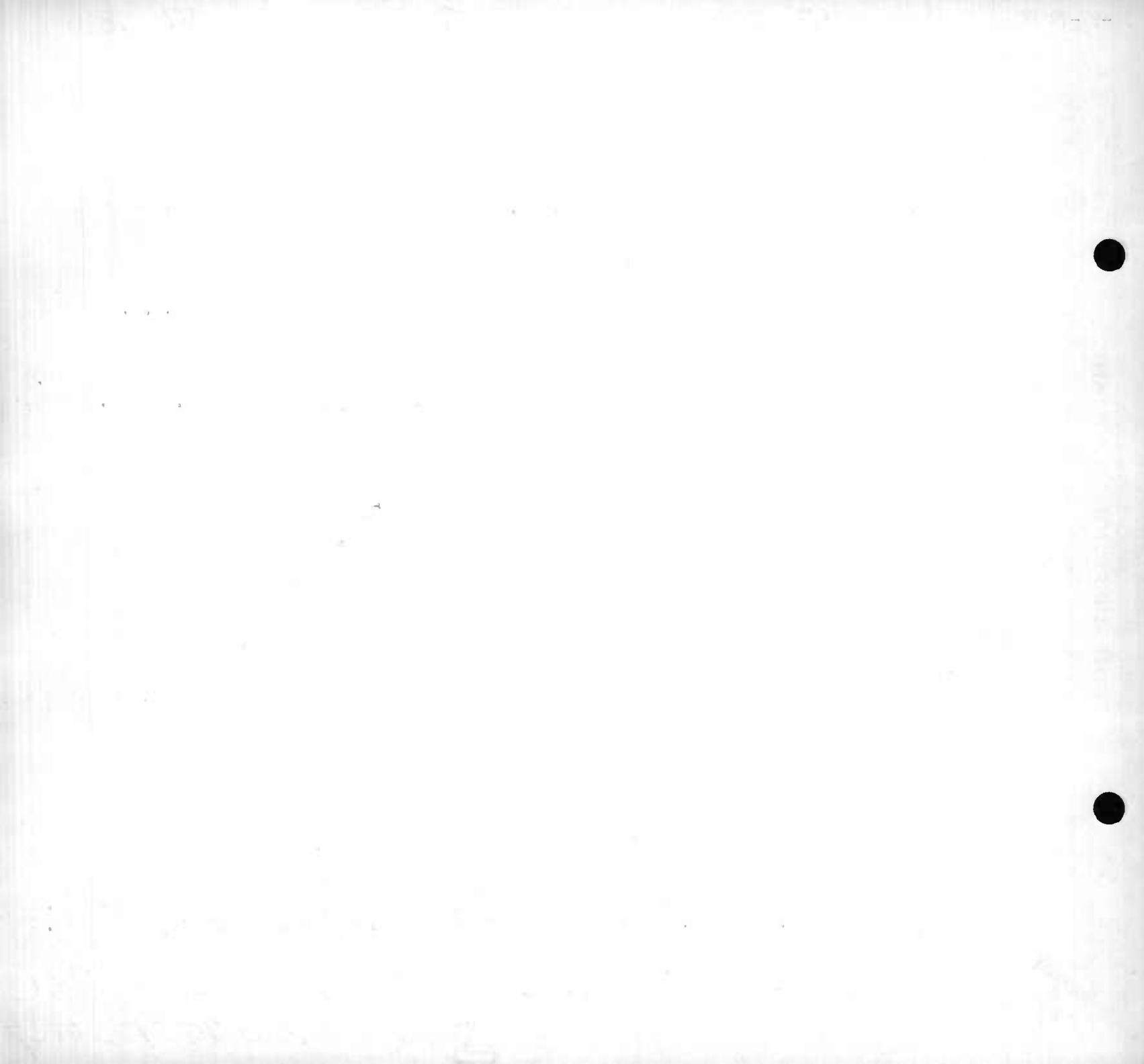
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-84-34 IN		67 7809		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7809	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CLERKLEY, Maseo (Maceo)				2. DATE AND HOUR OF DEATH 8/10/67 12:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1327 Edmondson Avenue - 21223			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/21/03	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL Clerkley			14. MOTHER'S MAIDEN NAME ANNIE P				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224		
18. 1977, 9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Malignant Mesothelioma. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) DUE TO			
				(C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/3/1967 to 8/10/1967 , that (I) (we) last saw the deceased alive on 8/10/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W Stan Wilson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/10/67			
23C. PHYSICIAN'S NAME (Type) W Stan Wilson				23D. ADDRESS BCH. 4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14/67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem Balto		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E Preston St	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7810		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7810	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PEARLIE COVINGTON		2. DATE AND HOUR OF DEATH 8/11/67 1425 p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE City HOSPITAL 4940 EASTERN AVENUE BALTIMORE 21224, MD.		D. STREET ADDRESS (If rural, give location) 1304 N. CAROLINE ST. - 21213		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/30/31	9. AGE (In years lost birthday) 36	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD MCKINNEY		14. MOTHER'S MAIDEN NAME PEARL MCGRAW		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCM 4940 EASTERN AVE. BALTO. 21224,		ADDRESS MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARRHYTHMIA		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH IMMED	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C) METASTATIC ADENOCARCINOMA OF THE COLON		5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/7 19 67 to 8/11 19 67 , that (I) (we) last saw the deceased alive on 8/11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (<u>did not</u>) view the body after death.					
23A. SIGNATURE David E McBeth		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) DR. DAVID E. MC BETH DAVID E. MCBETH		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. 6060 E. PRATT ST. BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-67		24C. NAME of CEMETERY or CREMATORY Greenwood Memorial Park Prince Geo Co. Md	
24D. LOCATION (City, town, or county) (State) BALTO. 21224		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 217 E. Preston St			



1
B-500

67 7811

BALTIMORE CITY HEALTH DEPARTMENT

67 7811

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE A. BOWEN, SR.

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1967 4:02 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)44
99

Union Memorial Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1713 Wadsworth Way

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

JULY 27, 1884

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CLERK RET.

10B. KIND OF BUSINESS OR INDUSTRY

MUNICIPAL CLERK

11. BIRTHPLACE (State or foreign country)

N.J.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

GEO. A. BOWER

14. MOTHER'S MAIDEN NAME

VIOLA WIESCHEDLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

152-09-0869

17. INFORMANT

GEO. A. BOWER JR.

ADDRESS

SAME

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Removal/Burial 8-15-67

ST. PETERS Cem

NEW BRUNSWICK N.J.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1967

Robert E. Jenkins

Holt Jenkins & Sons Co. York Rd

Barto, MD. 21212

B-655

67 7812

BALTIMORE CITY HEALTH DEPARTMENT

67 7812

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

EDWARD

J.

BRENNAN, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

August 10, 1967

10:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

213 Tunbridge Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

213 Tunbridge Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/5/1926

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Brokerage Firm of
Registered Repres. Francis I. Dupont

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward J. Brennan

14. MOTHER'S MAIDEN NAME

Estell Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

220-20-1815

17. INFORMANT

Mrs. Mary Brennan

ADDRESS

(Same)

18.

E 970.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Barbiturate Overdose
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

213 Tunbridge Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 10 '67 UNK

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. ingested
an overdose of barbiturates

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/14/1967

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

Baltimore

(State)
Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

Robert E. Salisbury

24C. FUNERAL DIRECTOR

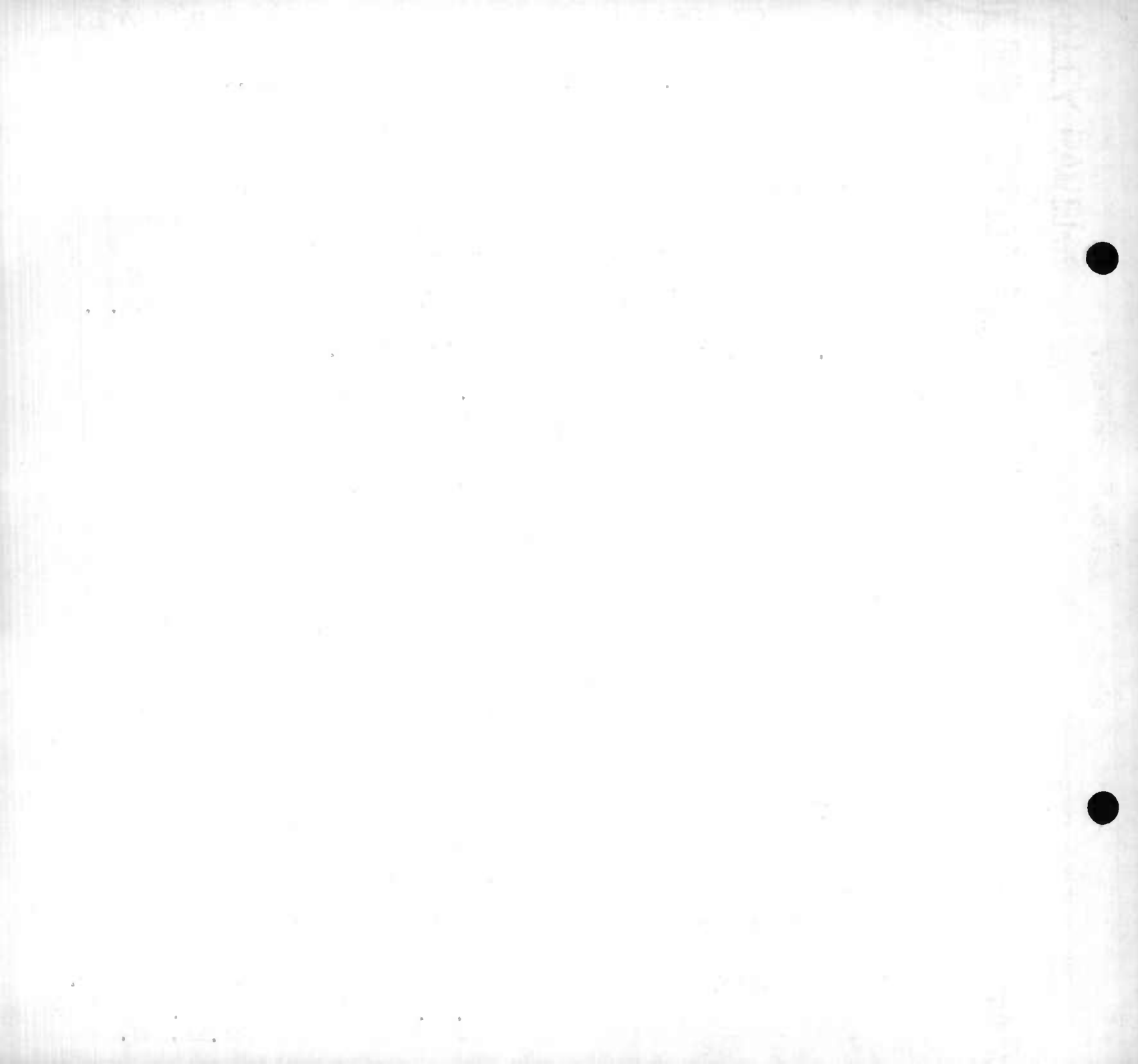
H. W. Jenkins & Sons Co. 4905 York Rd
Balto. 12, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7813				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7813	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Marie A. Frederick			
2. DATE AND HOUR OF DEATH				August 13, 1967 7:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Gould Convalesarium				Maryland 27-34			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				6116 Belair Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
F	W	Never Married	3-21-1893	74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			Own Home		Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles H. Frederick				Elizabeth M. Frederick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mr. John Frederick 727 Milyer Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) CARCINOMA OF BLADDER DUE TO WITH METASTASIS			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 7 19 67 to AUGUST 13 19 67, that (I) (we) last saw the deceased alive on JULY 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert E. May M.D.						23B. DATE SIGNED 8/14/66.	
23C. PHYSICIAN'S NAME (Type) Robert May				23D. ADDRESS M.D. 5662 The Alameda			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/16/67		Holy Redeemer		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1967		Robert E. May		H. W. Jenkins & Sons Co.		4905 York Rd Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7814		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7814	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Sadie R. Dudley (Dudley)			2. DATE AND HOUR OF DEATH 8/14/67 11:15 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1112 Ramblewood Road		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/26/1875	9. AGE (In years last birthday) 92	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel R. Tracey			14. MOTHER'S MAIDEN NAME Eliza Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-48-4968-J	17. INFORMANT ADDRESS Miss Blanche Wagner (Same)		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardio Vasculum Disease Senility					
19. DATE OF OPERATION 8/20/67					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Senility					
20A. AUTOPSY? (Yes or No) No					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Aug 1967 , that (I) (we) last saw the deceased alive on Aug 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M Paul Byerly			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/67
23C. PHYSICIAN'S NAME (Type) M Paul Byerly			23D. ADDRESS 5820 York Rd Baltimore 22		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/67	24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR W. E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.	

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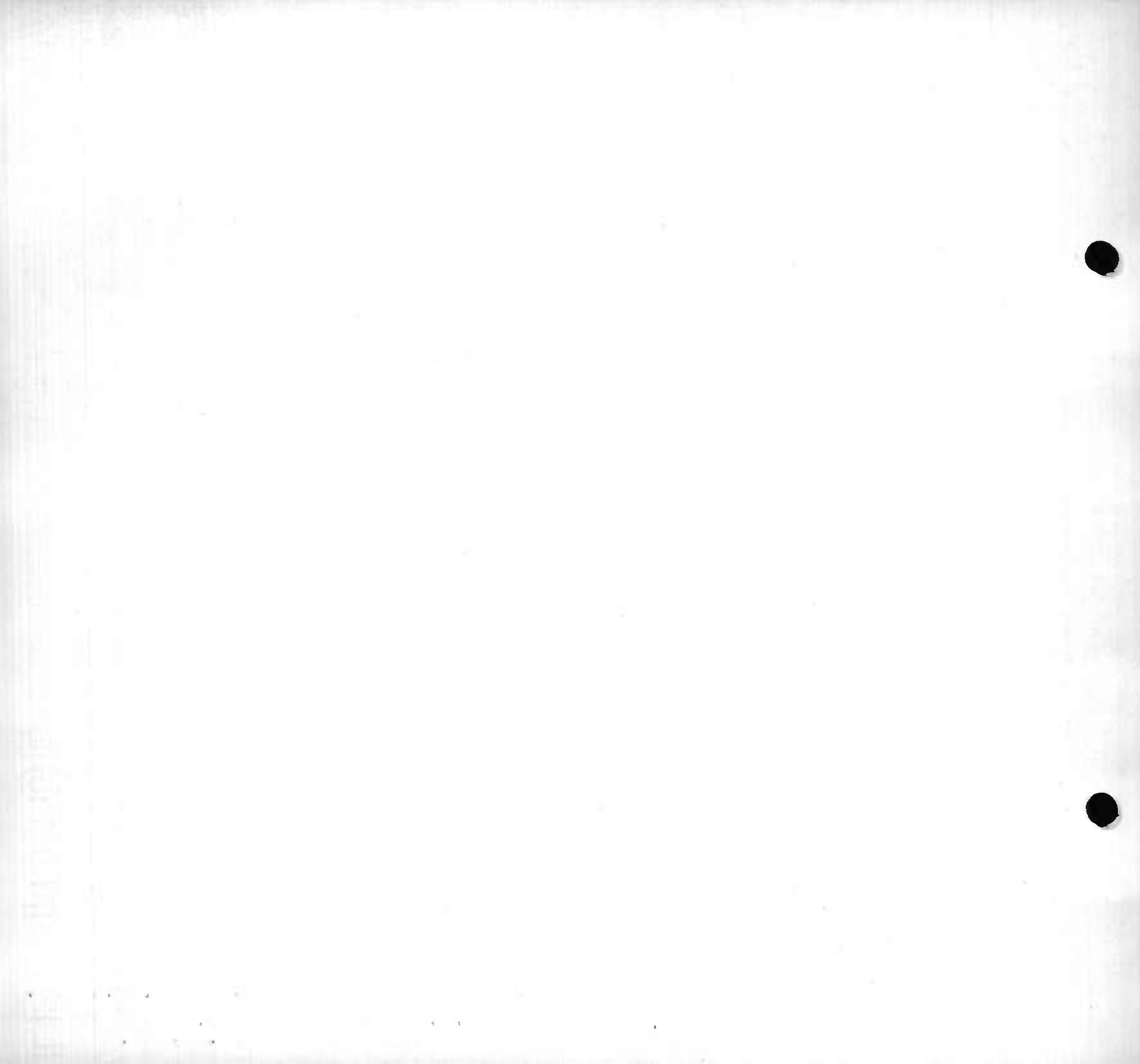
Handwritten text, possibly a date or short note, located in the lower middle section of the page.

Handwritten text, possibly a signature or name, located in the bottom section of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7815	
BIRTH NO. 67 7815		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William A. Gillespie		2. DATE AND HOUR OF DEATH 8-13-67 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12-03			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO-			
		D. STREET ADDRESS (If rural, give location) 2645 N. CALVERT ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 10-25-81	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CPA		10B. KIND OF BUSINESS OR INDUSTRY AUDITING		11. BIRTHPLACE (State or foreign country) BALTO.	
13. FATHER'S NAME James m. Gillespie.			14. MOTHER'S MAIDEN NAME AMELIA KEEN NAMUTH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-1306		17. INFORMANT 1618 WINFORD RD ADDRESS 2012 WILLIAM A. GILLESPIE, JR.	
18. 422.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebrovascular accident DUE TO		7 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerotic cardiovascular disease DUE TO		years	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/16/67 19 67 to 8/13 19 67 , that (I) (we) last saw the deceased alive on Aug 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Stern				23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) KENNETH STERN		23D. ADDRESS M.D. MERCY HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA

I.

LLOYD

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1967

1:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

1026 Courtney Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9/16/22

9. AGE (in years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Carr Lowery Glass Co.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Russell F. Newhard

14. MOTHER'S MAIDEN NAME

Georgia A. Kraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
220-14-717817. INFORMANT ADDRESS
Mr. John Lloyd
1026 Courtney Rd. - 21227

18. 581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Alteration of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/14/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

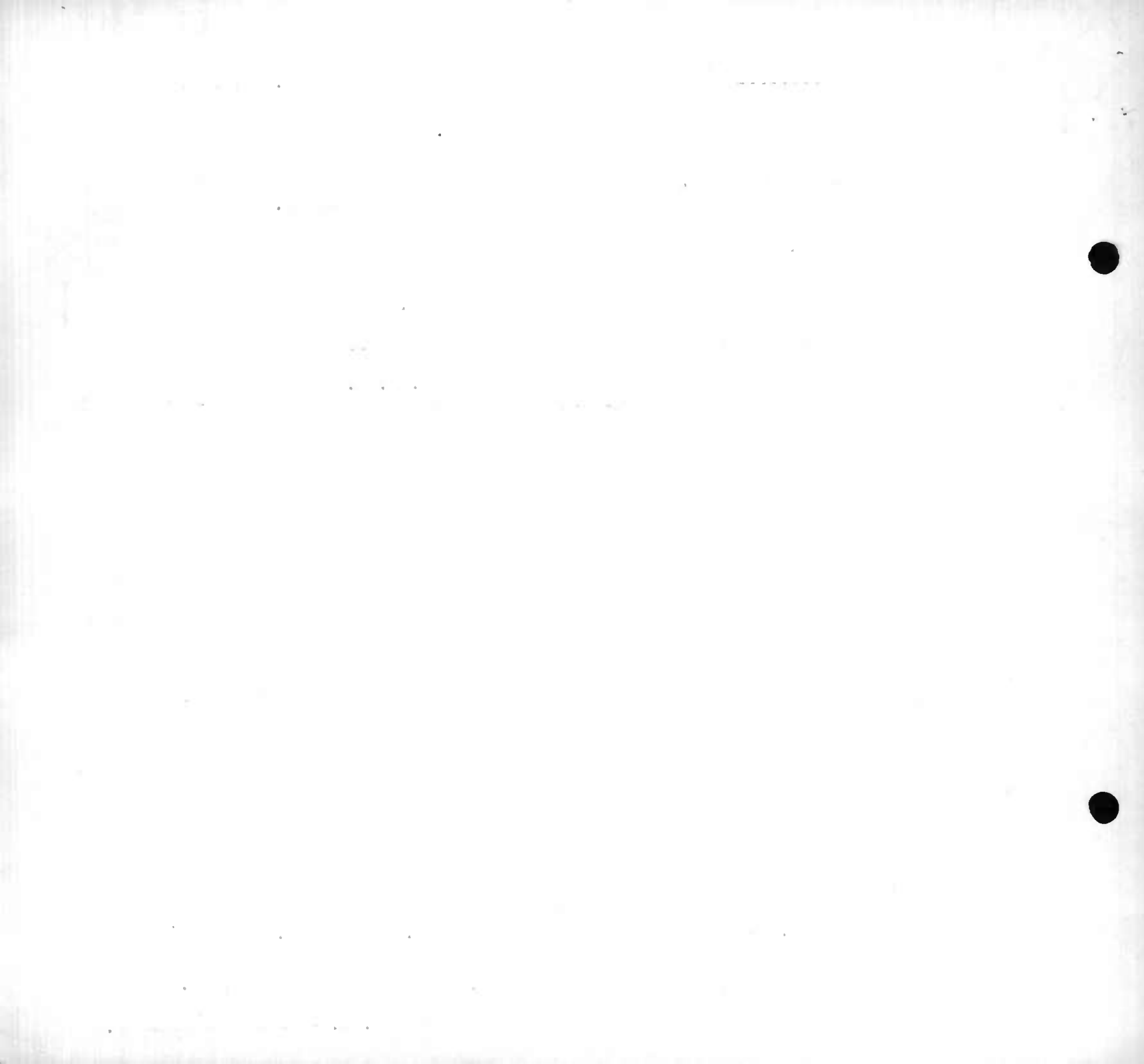
Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7817	
BIRTH NO. 67 7817		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jeannette Joannette Musk		2. DATE AND HOUR OF DEATH Aug. 11, 1967 9:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
00 4502 Manordene Rd.		Md.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		4502 Manordene Rd.			
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/21/93	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Mass.	
13. FATHER'S NAME Merrell		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 351-20-5745		17. INFORMANT ADDRESS	
				Mr. H. A. Musk 7833 Americana Circle - Glen Burne	
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Coronary Thrombosis		15 min	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO A.S.C.V. disease		>	
		(C) DUE TO Cardiac Failure		2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 1964 to August 11, 1967, that (I) (we) last saw the deceased alive on July 28, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE D. C. MacLaughlin M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/12/67	
23C. PHYSICIAN'S NAME (Type) D. C. MacLaughlin M.D.		23D. ADDRESS 303 N. Rolling Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/14/67	24C. NAME of CEMETERY or CREMATORY Meadowridge Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmondson Av.	



BIRTH NO.		67 7818		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 7818	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) JOSEPH DARDA					2. DATE AND HOUR PRONOUNCED DEAD August 12, 1967 2:50 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE Maryland				
00 259 S. Ann Street					C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-02				
D. STREET ADDRESS (If rural, give location) 259 S. Ann Street									
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 1889 ?		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pol and		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lawrence Darda					14. MOTHER'S MAIDEN NAME Katarzyna ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-1829		17. INFORMANT ADDRESS Angela. Amelia Darda 259 South Ann Street					
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic heart disease									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/16/67		23C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		23D. LOCATION (City, town, or county) (State) German Hill Rd, Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		24B. NAME OF REGISTRAR Robert E. Fiedler		24C. FUNERAL DIRECTOR ADDRESS George A. Weber 705 South Ann Street					

FUNERAL DIRECTOR: IMPORTANT

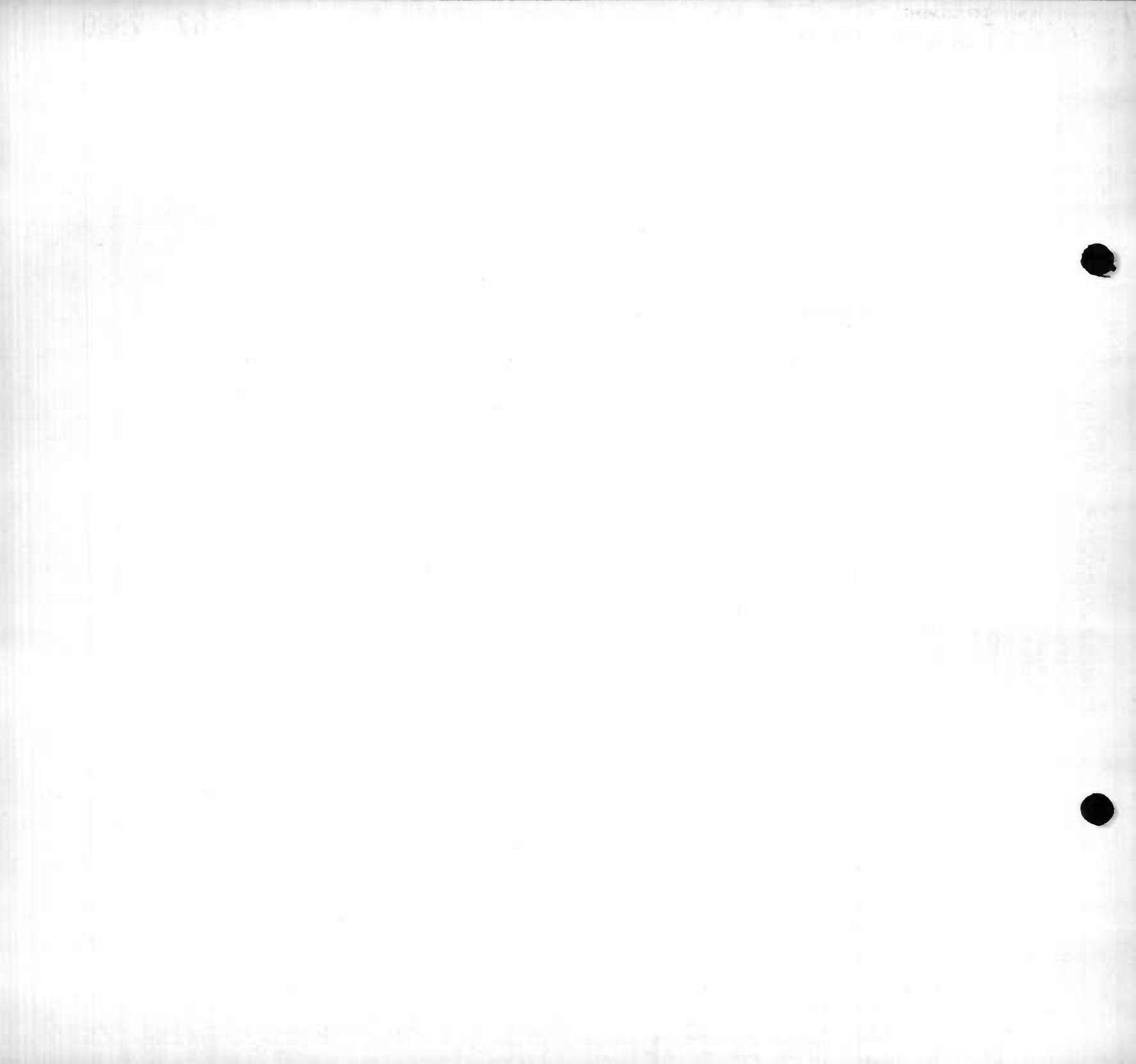
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67-1819</u>	
BIRTH NO. <u>67 7819</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Thomas Allen</u>		2. DATE AND HOUR OF DEATH <u>8-11-67</u> <u>3³⁰</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>99 Botton Hill Nursing Home</u>		A. STATE <u>md</u> B. COUNTY <u>17-02</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore md.</u>			
		D. STREET ADDRESS (If rural, give location) <u>650 W. Hoffman St.</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT 20, 1881</u>	9. AGE (In years last birthday) <u>85</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ALIEN WORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Yellow Cab</u>		11. BIRTHPLACE (State or foreign country) <u>GOWANS, BALTO Co, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>John Nicholas Allen</u>		14. MOTHER'S MAIDEN NAME <u>ANNA GASSAWAY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>320 1265424</u>		17. INFORMANT <u>MRS. ANNA E. ALLEN</u>	
				ADDRESS <u>650 W. Hoffman St</u>	
18. <u>4-20-01</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>arteriosclerotic heart disease</u> DUE TO		<u>yes</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>arteriosclerosis</u> DUE TO		<u>yes</u>	
		(C) <u>malnutrition and debility</u> DUE TO		<u>yes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> 19 <u>67</u> to <u>8/11</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/11</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALLAN H. MACHT</u> M.D.				23B. DATE SIGNED <u>8/11/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT</u>		23D. ADDRESS <u>2 E REAG. ST BALTIMORE MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/14/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CARVER MEMORIAL PARK</u>	
24D. LOCATION <u>LAUREL</u>		24E. CITY, TOWN, OR COUNTY <u>MARYLAND</u>		24F. STATE <u>MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1967</u>		25B. NAME OF REGISTRAR <u>Herbert E. Witten</u>		25C. FUNERAL DIRECTOR <u>3035 W. North Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

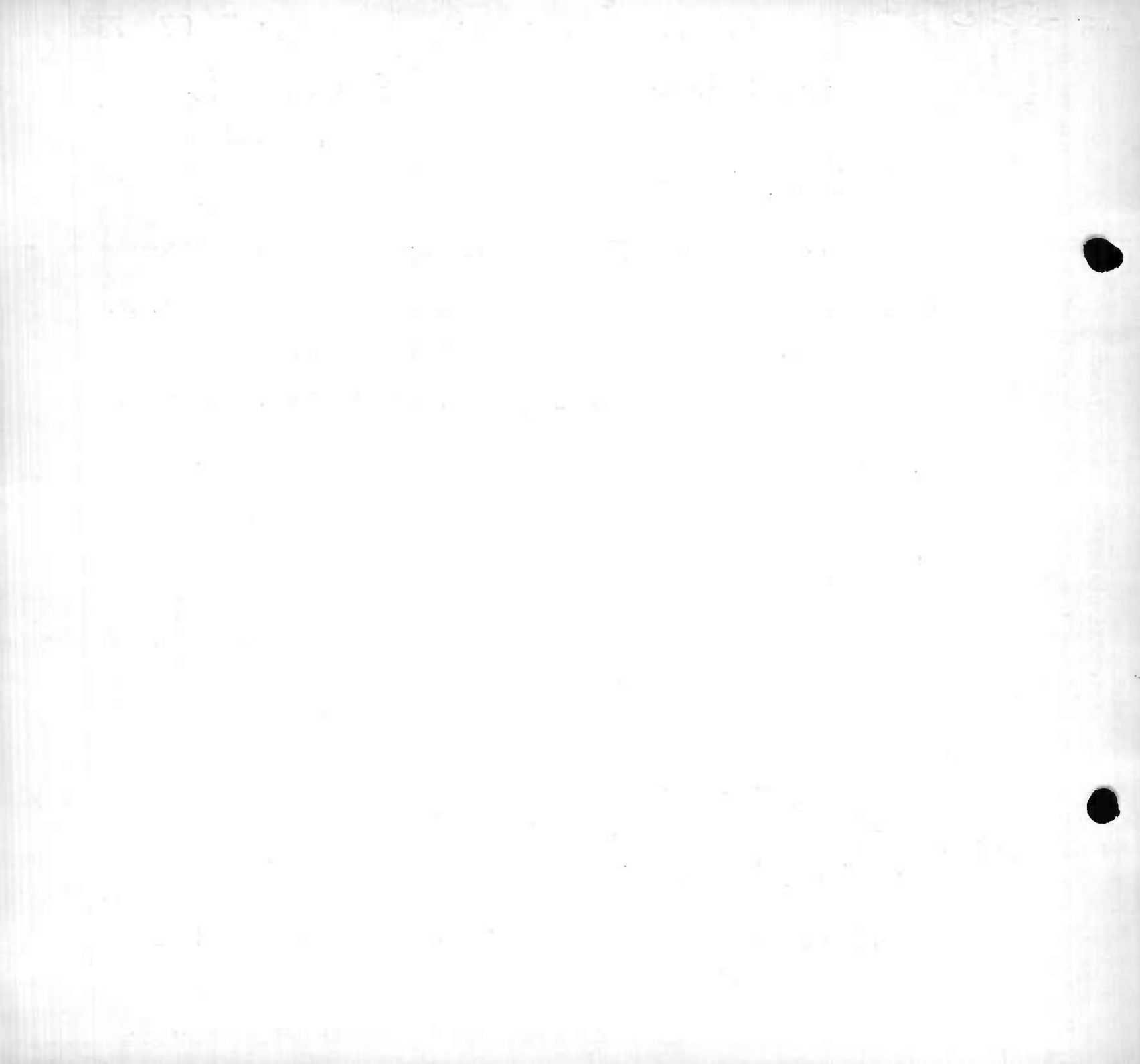
BALTIMORE CITY HEALTH DEPARTMENT										
67 7820					Registered No. 67 7820					
CERTIFICATE OF DEATH										
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MILTON WIENECKE					2. DATE AND HOUR OF DEATH 8-14-1967 9:15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL OF MARYLAND					A. STATE MARYLAND					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26 70					
					D. STREET ADDRESS (If rural, give location) 3234 EAST BALTIMORE ST.					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6-1-01	9. AGE (In years last birthday) 66	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE PRESIDENT			10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		13. FATHER'S NAME PHILIP WIENECKE SR			14. MOTHER'S MAIDEN NAME ANNA WITTSTADT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-09-0521A		17. INFORMANT CHART			ADDRESS		
18. 162.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA					CAUSE OF DEATH (A) DUE TO SECONDARIES IN LIVER					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PRIMARY CA. of LUNG?					(B) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO					
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 8-1-1967 to 8-14-1967 , that (I) (we) last saw the deceased alive on 8-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE S. Aziz					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) S. AZIZ					23D. ADDRESS M.D. LUTHERAN HOSPITAL OF MARYLAND BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 8/17/67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY COLGATE MD			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR ADDRESS ULORRH FUNERAL HOME 4210 BELAIR				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7821	
CERTIFICATE OF DEATH				Registered No. 67 7821	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				HEINS, FRED	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
8/12/67 1:15 PM		THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. SEX			
MARYLAND, BALTIMORE Co.		M			
6. COUNTY		7. RACE		8. DATE OF BIRTH	
BALTIMORE		W		3-30-87	
9. CITY OR TOWN (If outside city limits, write RURAL and give township)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BALTIMORE		Steel		Canada	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		EDWARD HEINS		HERMIONA PRATT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		238-24-3524A		Mrs. Mary Tice 702 S. Robinson St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		20. INTERVAL BETWEEN ONSET AND DEATH	
162.1 I		bronchogenic carcinoma			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Chronic bronchitis & pulm. edema & pneumonitis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		No		No	
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY (Yes or No)	
				No	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR?	
<input type="checkbox"/>				<input type="checkbox"/>	
29. TIME OF INJURY (Month) (Day) (Year) (Hour)		30. INJURY OCCURRED		31. HOW DID INJURY OCCUR?	
		<input type="checkbox"/> While At Work <input type="checkbox"/> Not While At Work			
32. I certify that (I) (this hospital) attended the deceased from Aug 9 1967 to Aug 12 1967 , that (I) (we) last saw the deceased alive on Aug 12 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
33. SIGNATURE		34. M.D. Attending Phys.		35. DATE SIGNED	
Philip R. Reid		<input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys.		Aug. 12, 1967	
36. PHYSICIAN'S NAME (Type)		37. ADDRESS		38. DATE OF BURIAL	
PHILIP R. REID		THE JOHNS HOPKINS HOSPITAL		8/16/67	
39. BURIAL CREMATION, REMOVAL (Specify)		40. NAME OF CEMETERY or CREMATORY		41. LOCATION (City, town, or county) (State)	
Burial		Cedar Hill Cemetery		Brooklyn, Md.	
42. DATE REC'D BY HEALTH DEPT.		43. NAME OF REGISTRAR		44. FUNERAL DIRECTOR ADDRESS	
AUG 15 1967		Robert E. T. ...		Ulrich Funeral Home Dundalk, Md.	



CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ANNA SIEMEK

Siemek, Anna K

(SEIMEK)

2. DATE AND HOUR OF DEATH

8-14-67

12 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO.

53-00

D. STREET ADDRESS (If rural, give location)

2702 Gray Manor Court #21222

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

July 26, 1886

9. AGE (In years
last birth day)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis

14. MOTHER'S MAIDEN NAME

Josephine

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NO

17. INFORMANT

RECORDS:

BCN 4940 Eastern Avenue

Baltimore, Maryland #21224

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

1A) DUE TO PNEUMONITIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

1B) DUE TO CVA

(C) CHRONIC ASCUD

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-6 19 07 to 8-14 19 67,
that (I) (we) last saw the deceased alive on 8-14 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

P. Desmond

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-14-67

23C. PHYSICIAN'S
NAME (Type)

P. Desmond

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

15otel

Burial

8-18-67

Holy Rosary Cem.

Balto.

Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1967

25B. NAME OF REGISTRAR

Robert E. Fialkowski

25C. FUNERAL DIRECTOR

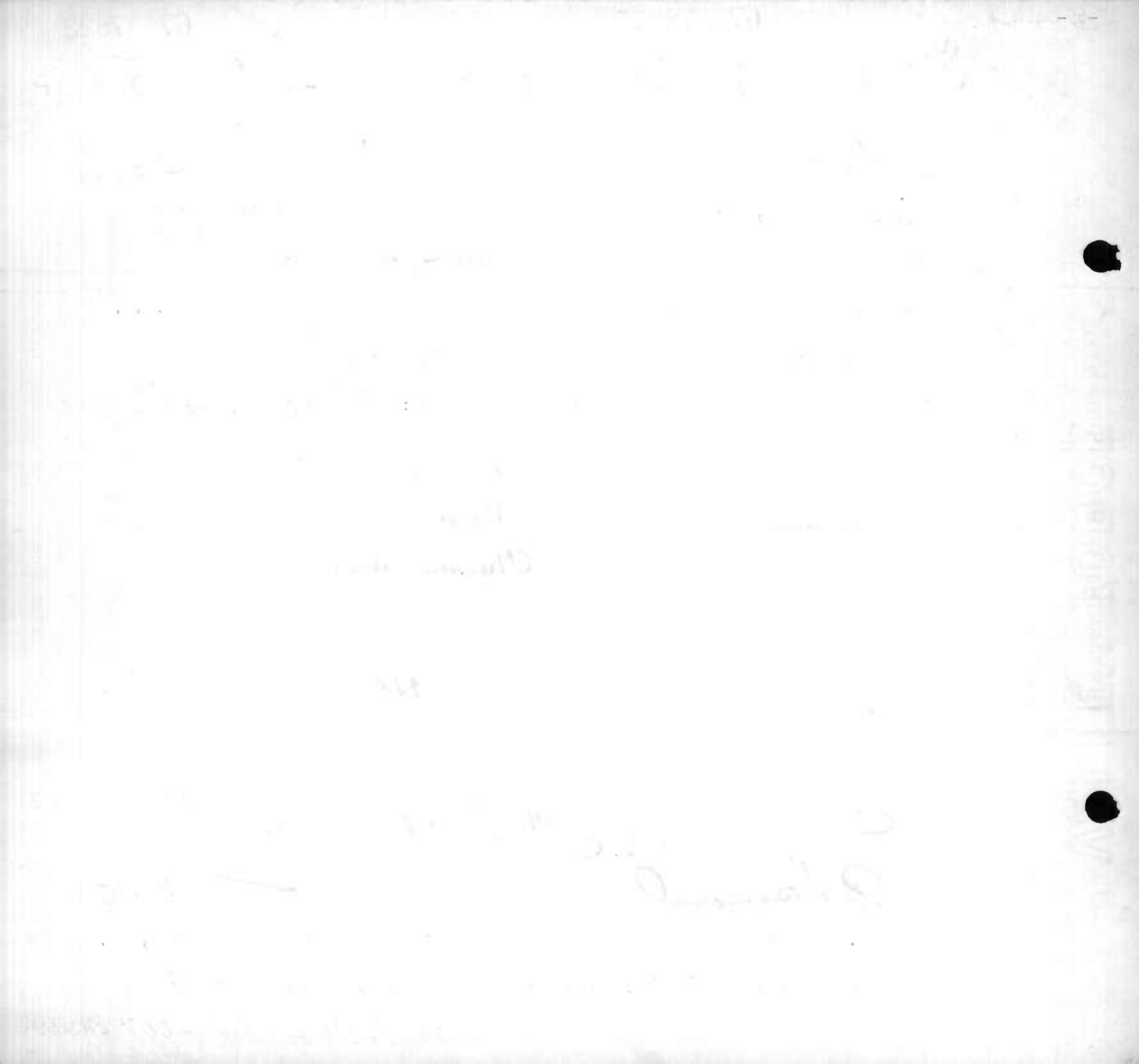
Wm. Fialkowski

ADDRESS

2007 Eastern
Balto. Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7823	
BIRTH NO. 67 7823		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Valentine J. Kozarski		2. DATE AND HOUR OF DEATH Aug. 13 1967 2:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Valentine Kozarski		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	
8. DATE OF BIRTH 2/13/12		9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Julius Kozarski	
14. MOTHER'S MAIDEN NAME Katherine		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-7782	
17. INFORMANT Ida Kozarski		18. ADDRESS 2306 Boston St.		19. MOTHER'S MAIDEN NAME Mrs. Katherine Vendetti	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH approximately 2 mo.	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1. Emphysema		20. ANTECEDENT CAUSES 2. Atherosclerotic Vascular Disease		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
22. I certify that (I) (this hospital) attended the deceased from Aug 1 19 67 to Aug 13 19 67 , that (I) lost lost saw the deceased alive on Aug 12 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.		23. SIGNATURE Edward H. Lazar M.D.		24. DATE SIGNED Aug 13, 1967	
25. PHYSICIAN'S NAME (Type) Edward H. LAZAR M.D.		26. ADDRESS Sinai Hospital of Baltimore		27. DATE REC'D BY HEALTH DEPT. AUG 15 1967	
28. NAME OF REGISTRAR Robert E. Finkbeiner		29. FUNERAL DIRECTOR Lilly & Zeiler Inc.		30. ADDRESS 1901 Eastern Ave.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN

M.

GRAFF

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1967

12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

636 S. Kenwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

636 S. Kenwood Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Sept. 14, 1893

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Nelson

14. MOTHER'S MAIDEN NAME

Catherine Friedel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-44-9811

17. INFORMANT

James J. Graff 4604 Belvieu Avenue

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/13/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-18-1967

23C. NAME of CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

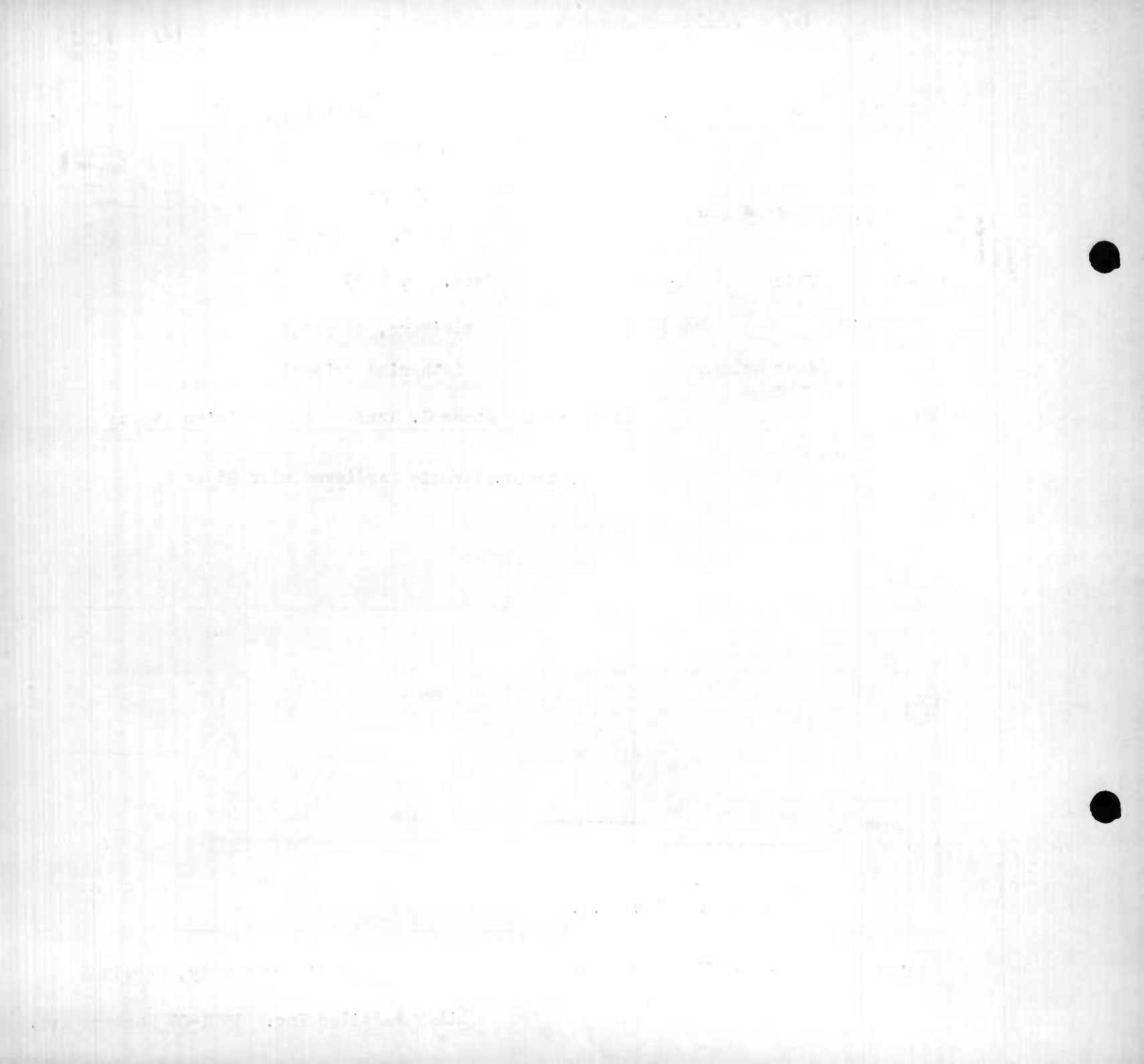
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1967

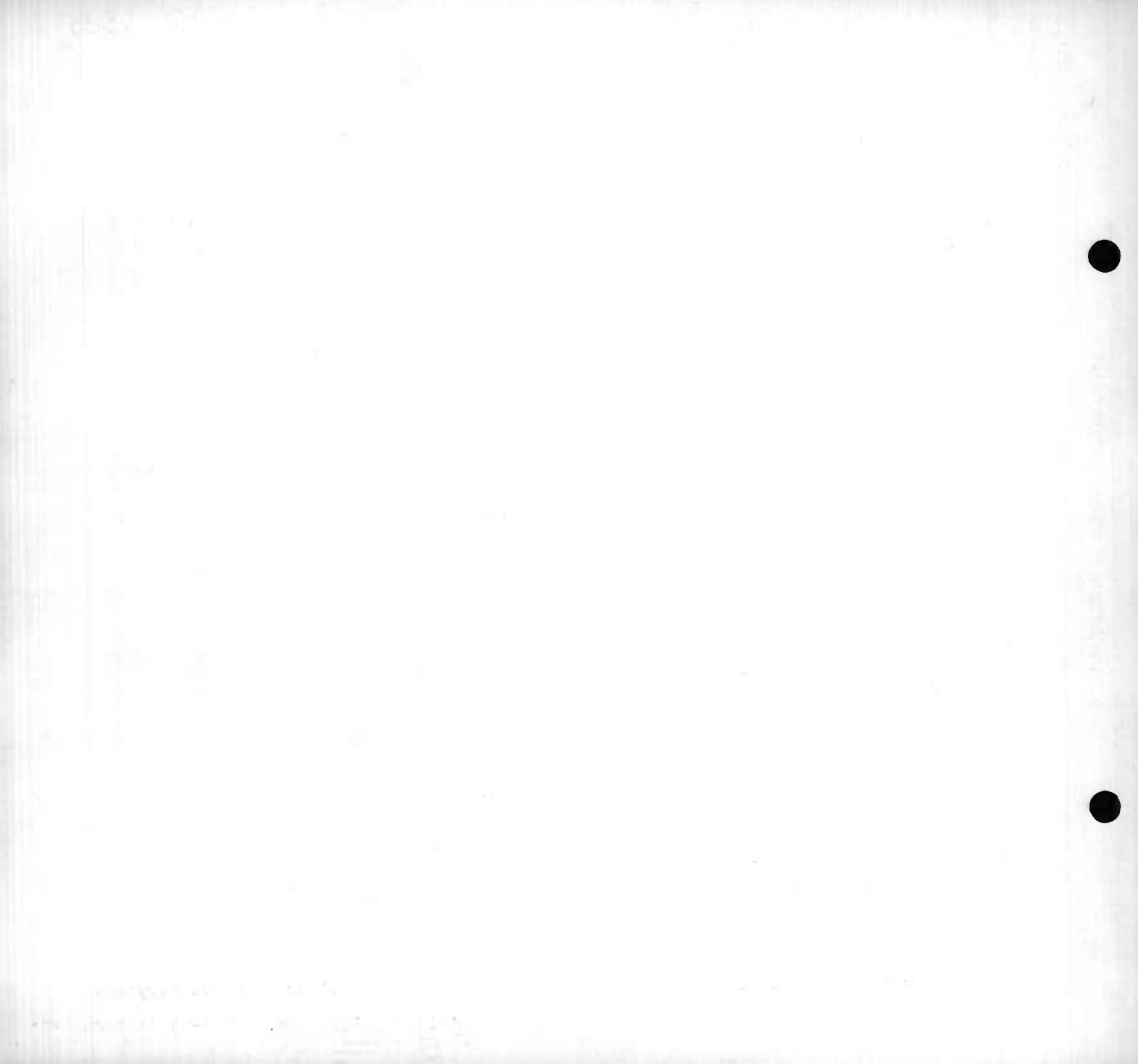
Lilly & Zeller Inc. 1901-07 Eastern Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7825	
BIRTH NO. 67 7825		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED GEORGE H. EVANS		2. DATE AND HOUR OF DEATH 8/14/67 15:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 810 S. CLINTON ST.			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 810 S. CLINTON ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/9/10	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bridge inspector		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME George Evans		14. MOTHER'S MAIDEN NAME Irene Law		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT HOSP. CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cirrhosis of liver with acute decompensation & bronchopneumonia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH ? years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. bronchopneumonia		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8/9/67</u> 19 <u>67</u> to <u>8/14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Stern				23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) KENNETH STERN		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-1967		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967			
25B. NAME OF REGISTRAR Reuben E. Johnson		25C. FUNERAL DIRECTOR Lilly & Zeller Inc. 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 7826		67 7826	
CERTIFICATE OF DEATH					
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			August 13, 1967 3:45 p.m. M.		
SAUERWEIN ANNA M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
CHURCH HOME AND HOSPITAL, BALTIMORE, MD.			MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			CHURCH HOME & HOSPITAL		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	WHITE	WIDOW	1-6-75	92 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CHURCH HOME RESIDENT		RETIRED HOMEMAKER		Massachusetts.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JOHN MAXWELL			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			220-46-0727		Son - MR. E.M. SAUERWEIN 2206 Dalewood Rd., Timon
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			Chronic Respiratory Insufficiency		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			Chronic Bronchitis and Emphysema		
			(C) DUE TO		
			Atelectasis, left lung		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			myocardial fatty degeneration		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? Yes or No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from August 10, 1967 to Aug. 13, 1967, that (I) (we) last saw the deceased alive on August 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Rodelio M. Lin			8-11-67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Rodelio M. Lin			CHH Church Home and Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	8/16/1967	Greenmount	Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 15 1967		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	

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LIBRARY

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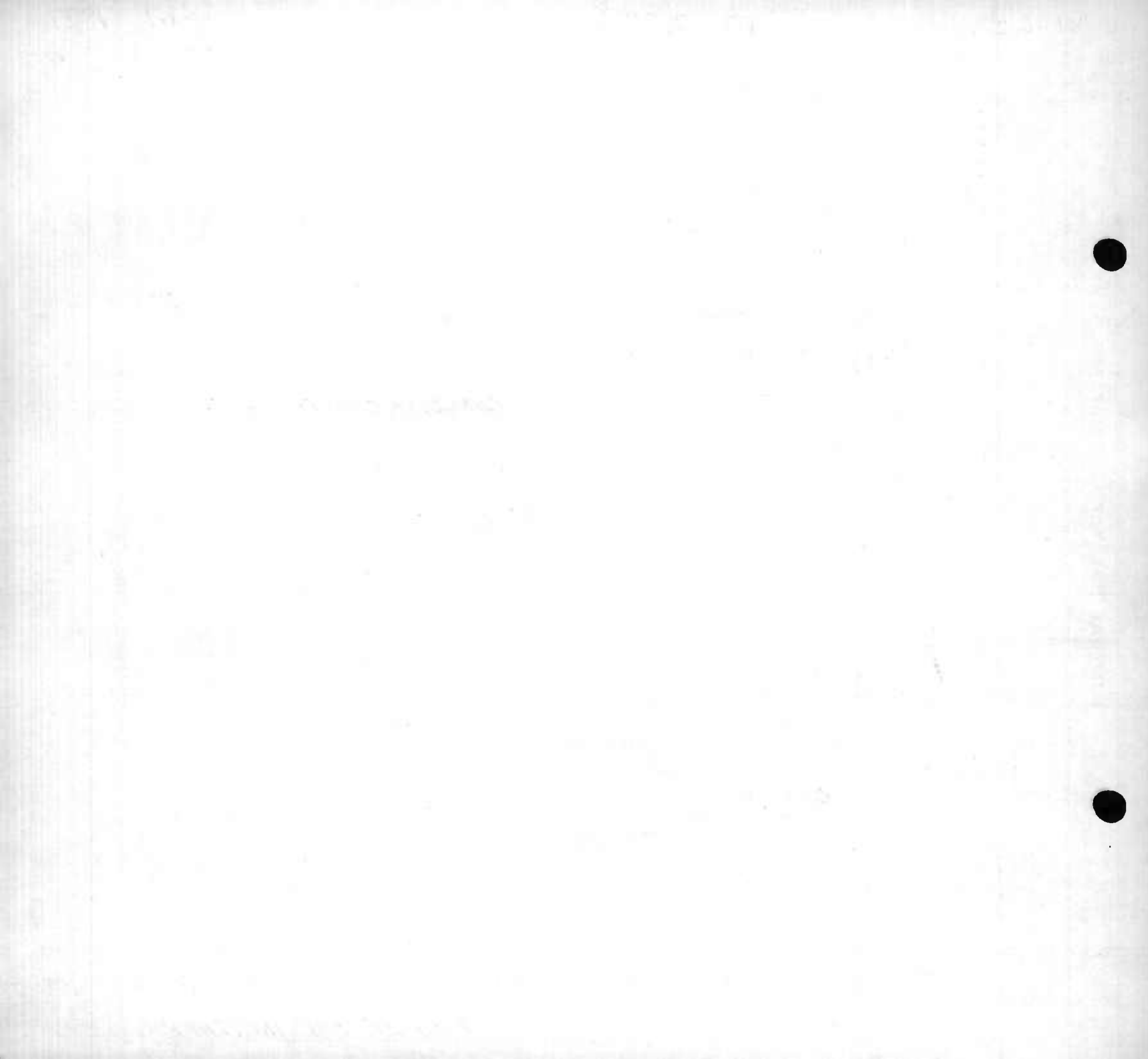
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CHICAGO, ILL. 60607
TEL. 777-3000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7827		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7827	
1. NAME OF DECEASED (Type or Print) <i>Myers, Nellie H.</i>			2. DATE AND HOUR OF DEATH <i>8/14/67 4:05 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3719 Overlea Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widow</i>	8. DATE OF BIRTH <i>3-26-82</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>?</i>
13. FATHER'S NAME <i>Henry Halford Myers</i>			14. MOTHER'S MAIDEN NAME <i>Maria Smallwood</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT ADDRESS <i>CHANDLER O. MYERS 3719 OVERLEA AVE.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic carcinoma of stomach</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>perforation + peritonitis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>8/13/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>bowel perforation</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>8/12</i> 19 <i>67</i> to <i>8/14</i> 19 <i>67</i> , that (we) last saw the deceased alive on <i>8/14</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph L. Morris</i>				23B. DATE SIGNED <i>8/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Joseph L. Morris</i>		23D. ADDRESS M.D. <i>22 S. Greene St.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>8/16/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>DARKWOOD CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>TAYLOR AVE BALTO. MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1967</i>		25B. NAME OF REGISTRAR <i>R. B. E. Kelly</i>		25C. FUNERAL DIRECTOR ADDRESS <i>BIDDERL BRISING THORBELAIR RD.</i>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7828	
BIRTH NO. 67 7828		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anthony F. Sporney (or) Sporny		2. DATE AND HOUR OF DEATH Aug 13 - 67 11:59 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
FULL NAME OF HOSPITAL OR INSTITUTION 00 2716 E. Oliver St.		D. STREET ADDRESS (If rural, give location) 2716 E. Oliver St.		E. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 13 - 1909	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collector Salesman		10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Martin Sporny		14. MOTHER'S MAIDEN NAME Bertha Fox	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216015291		17. INFORMANT Cecelia Sporney (Wife)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1992 I		CAUSE OF DEATH (A) DUE TO Carcinoma of cheek Pharynx & jaw left. (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 17 mos	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2 May 1966 to present 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur G. Siwinski M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 14 August 1967	
23C. PHYSICIAN'S NAME (Type) Arthur G. Siwinski M.D.				23D. ADDRESS 836 Park Ave Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Burial Aug 17 - 67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cem.	
24D. LOCATION (City, town, or county) (State) Eastern Ave Rd. Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1967		25B. NAME OF REGISTRAR Robert E. Sullivan	
25C. FUNERAL DIRECTOR Chas. J. Appell		25D. ADDRESS 1800 E. Lombard St.			

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L-250

67 7829

BALTIMORE CITY HEALTH DEPARTMENT

67 7829

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MYRTLE

ROSE

LaShan

LASHAN

2. DATE AND HOUR PRONOUNCED DEAD

August 14, 1967

8:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 6209 Eunice Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6209 Eunice Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 22, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Clarence Reely

14. MOTHER'S MAIDEN NAME

Helen E. Becker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

218-07-6649

17. INFORMANT

ADDRESS

Mrs. Vernon Peacock 305 Third Av.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/18/67

23C. NAME OF CEMETERY or CREMATORY

Loudon Pk. Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

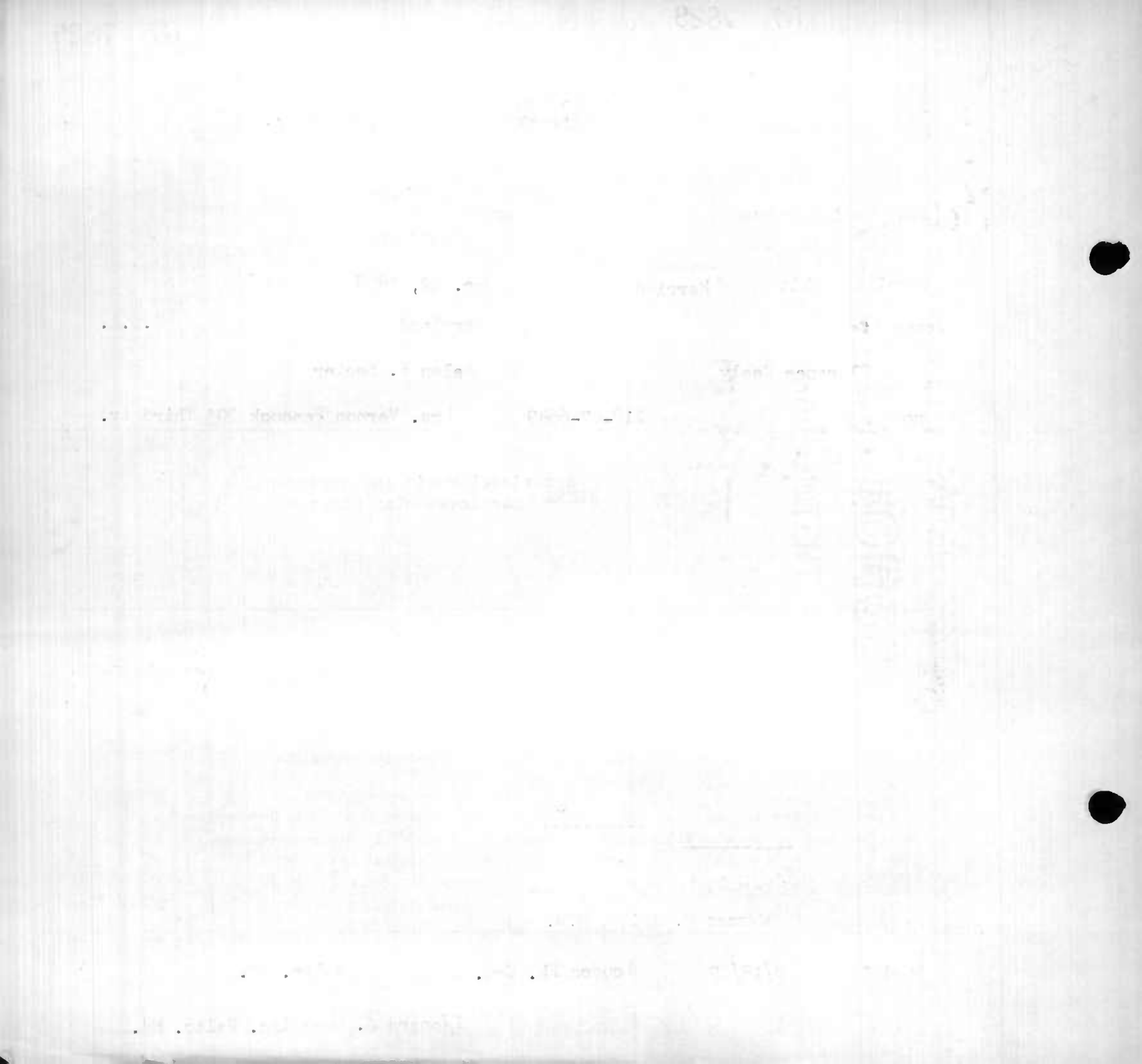
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 16 1967

Leonard J. Ruck Inc. Balto. Md.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7830

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICK

Henry

WRIGHT

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1967

6:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4037 Str. Monica Drive 1939 Merritt Blvd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/17/1902

9. AGE (in years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Langenfelder Contractors Maryland

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

William T. Wright

14. MOTHER'S MAIDEN NAME

Barbara Dittman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-01-9893

17. INFORMANT

ADDRESS

Thelma G. Wright same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/67

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

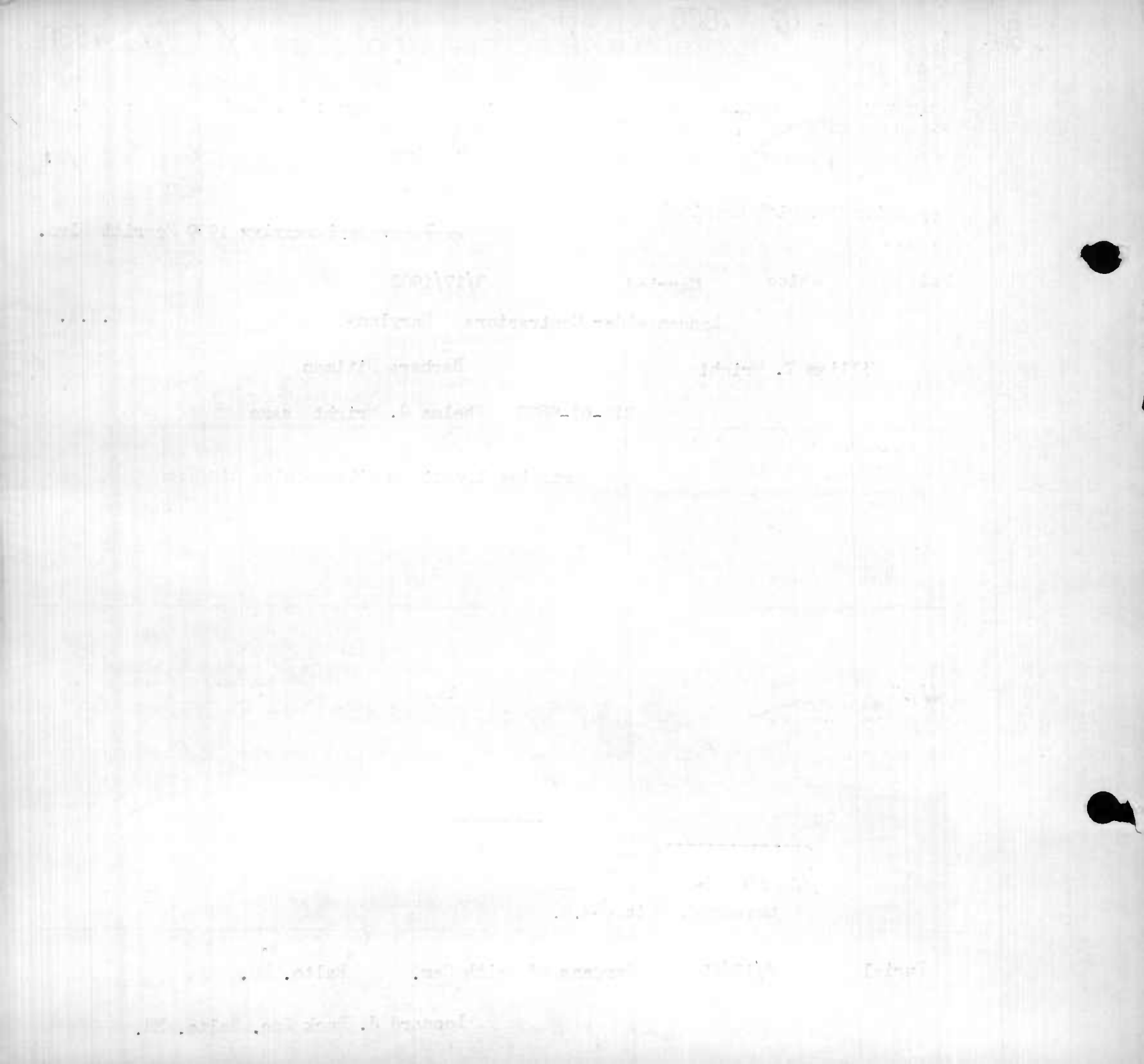
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 16 1967

Leonard J. Ruck Inc. Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7831		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7831	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Ethel Magness			2. DATE AND HOUR OF DEATH August 14, 1967 12 noon M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location) 4906 Ross Rd. #14			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 4906 Ross Rd., Balto. 14			E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 8/28/1889		9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wallace Coleman	
14. MOTHER'S MAIDEN NAME Katherine Hobbs		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-14-8313A	
17. INFORMANT Mrs. Estelle Drebing		ADDRESS 6114 Marieta Ave.		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) severe diabetes		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II guarded arterio-sclerosis; coronary artery disease		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 24 1964 to Aug 14 1967, that (I) last saw the deceased alive on Aug 14 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE L. C. Dobish		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) L. C. Dobish		23D. ADDRESS 447 N. Kenwood Ave Balto Md 11204			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/67		24C. NAME of CEMETERY or CREMATORY Loudon Pk. Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1967		24F. NAME OF REGISTRAR R. C. E. Fulkerson	
24G. FUNERAL DIRECTOR Leonard J. Ruck Inc.		24H. ADDRESS 5305 Harford Rd. #14		24I. DATE REC'D BY HEALTH DEPT. AUG 16 1967	

8/24/67 - Birth cert. #A-12671 - birth date: June 28, 1889.

J. B. Carter

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7832				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7832	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) REGAN, MARGARET				2. DATE AND HOUR OF DEATH AUGUST 13 1967 11:00P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL CATHOLIC & WILKENS AVE BALTIMORE MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY _____			
5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				6. STREET ADDRESS (If rural, give location) 1518 Holbrook St.			
6. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED widow	8. DATE OF BIRTH 12 25 79	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRELAND		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME THOMAS CREMIN (DECEASED)				
14. MOTHER'S MAIDEN NAME KIELEY (DECEASED) Nora			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 305-97-6461			17. INFORMANT ADDRESS ST AGNES HOSPITAL WILKENS AVE 21229				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cachexia			INTERVAL BETWEEN ONSET AND DEATH 6 months				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			20. DUE TO anorexia			6 months	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chronic brain syndrome			22. DUE TO chronic brain syndrome			1 year	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chronic anemia ? cause			24. DUE TO chronic anemia ? cause			years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initally medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 28 1967 to AUGUST 13 1967 , that (I) (we) last saw the deceased alive on AUGUST 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Raymond Gladue				23B. DATE SIGNED 8/13/67			
23C. PHYSICIAN'S NAME (Type) JOSEPH R GLADUE				23D. ADDRESS ST AGNES HOSPITAL WILKENS AVE 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR R. E. E. F. F.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	

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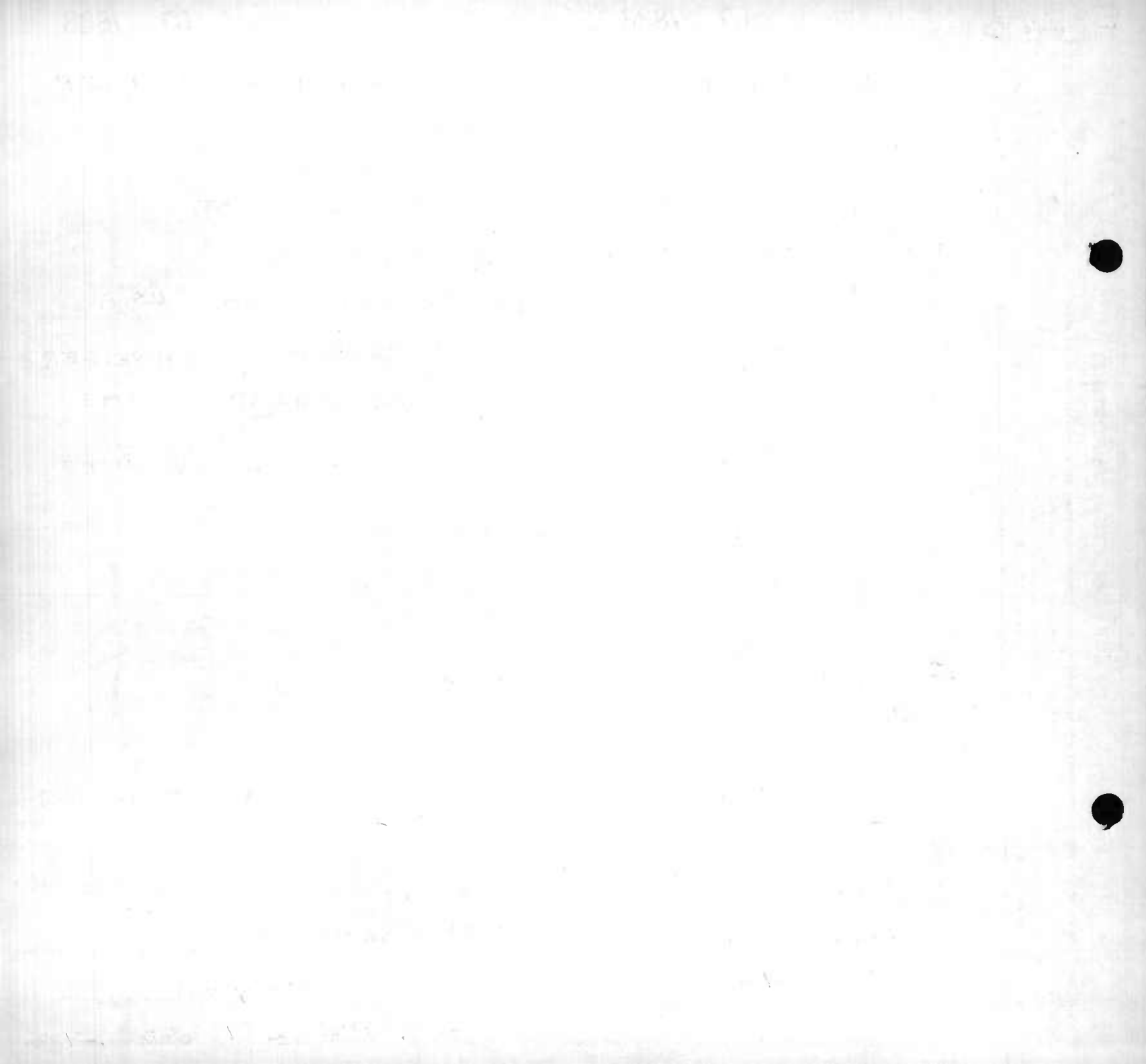
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7833		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7833	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDWARD DANIEL BOUGOURD		2. DATE AND HOUR OF DEATH AUGUST 12, 1967 1:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 00 2427 E. Oliver St.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2427 E. OLIVER ST	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-12-1905	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAILMAN		10B. KIND OF BUSINESS OR INDUSTRY U.S.A. MAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME JOHN NICHOLAS BOUGORD		14. MOTHER'S MAIDEN NAME ELIZABETH SCHWEIGER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ALVERTA BOUGOURD SAME	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) UNDIFFERENTIATED MALIGNANCY		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE		19A. DATE OF OPERATION 7-3-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BIOPSY OF TUMOR	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 2, 1965 to AUGUST 12, 1967 , that (I) (we) last saw the deceased alive on AUGUST 9, 1967 and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Paul G. Herold		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED August 12, 1967	
23C. PHYSICIAN'S NAME (Type) PAUL G. HEROLD		23D. ADDRESS M.D. 10 W. MADISON ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-15-67	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Don C. Miller Inc - 6415 Belair Rd. - 21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7834		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7834	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) MARTIN, JOHN HENRY		AUGUST 9, 1967		9:30A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		BALTIMORE	
ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD.		D. STREET ADDRESS (If rural, give location)		NURSING HOME	
315 INGLESIDE AVE, FOREST HAVEN		B. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE WHITE		APRIL 22, 1884		83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		WIDOWED		UNKNOWN	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN MARTIN (DEC'D)		WILHELMINA KIPP (DEC'D)		O	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(Yes, no or unknown) (If yes, give war or dates of service)		219 10 6771		ST. AGNES RECORDS-CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		PNEUMONITIS	
ANTECEDENT CAUSES		(B) DUE TO		GENERAL DEBILITY	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		HIP FRACTURE	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 5/11/67		fracture of hip		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
5/11/67		While At Work		Fall while lying bed	
22. I certify that (I) (this hospital) attended the deceased from		XO MAY 12, 1967 to		AUGUST 9, 1967	
that (I) (we) last saw the deceased alive on		AUGUST 9, 1967		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
DR. ROBERT COOK		M.D. Attending Phys. Med. Director Staff Phys.		08-09-67	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-11-67		Loudon Pk Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 16 1967		Robert E. Feltz		Helen A. Hoffman	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
3218 Hudson St.		3218 Hudson St.		3218 Hudson St.	

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67 7835 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7835

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

DAVID

PENN

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1967

12:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

Fair Haven

52-00

D. STREET ADDRESS (If rural, give location)

-242 Herring Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 21, 1883

9. AGE (In years
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Landscaping

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Penn

14. MOTHER'S MAIDEN NAME

Mary Disney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

- - -

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Edna R. Penn, Fair Haven, Maryland

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Gunshot of Head

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

242 Herring Avenue

03-01

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

August 11, 1967

10:00

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subj. shot self in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 14, 1967

23C. NAME of CEMETERY or CREMATORY

Friendship Chr. Cemetery

23D. LOCATION

(City, town, or county)

(State)

Friendship, A. A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1967

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

Hutchins Funeral Home (Bowie), Md.

ADDRESS

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1913

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7836 4	
BIRTH NO. 67-16395 67 7836 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Baby Girl Marie Catherine McLeewe		2. DATE AND HOUR OF DEATH 8/13/67 12⁰⁰ noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21205 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 7-02 D. STREET ADDRESS (If rural, give location) 825 N. Milton Ave.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 8/13/67
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? 1		13. FATHER'S NAME Paul McLeewe	
14. MOTHER'S MAIDEN NAME Frances Gillespie		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Father, above ADDRESS	
18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Immaturity</u> DUE TO (B) _____ DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/13/67 19 to 8/13/67 19, that (I) (we) last saw the deceased alive on 8/13/67 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Chester C. Collins MD M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) CHESTER C. COLLINS M.D.		23D. ADDRESS Mary Hos	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/67	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR R. E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 2601 E. Madison St.	

W. 7

W. 7

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7837

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES E. WAITUKITIES

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1967

8:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3507 Lyndale Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If usual, give location)

3507 Lyndale Avenue

#13

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

12/1/12

9. AGE (in years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

Lebow Bros.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Casimir Waitukities

14. MOTHER'S MAIDEN NAME

Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-07-2474

17. INFORMANT

ADDRESS

Rose Waitukities, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH420.0
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Balto., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1967

24B. NAME

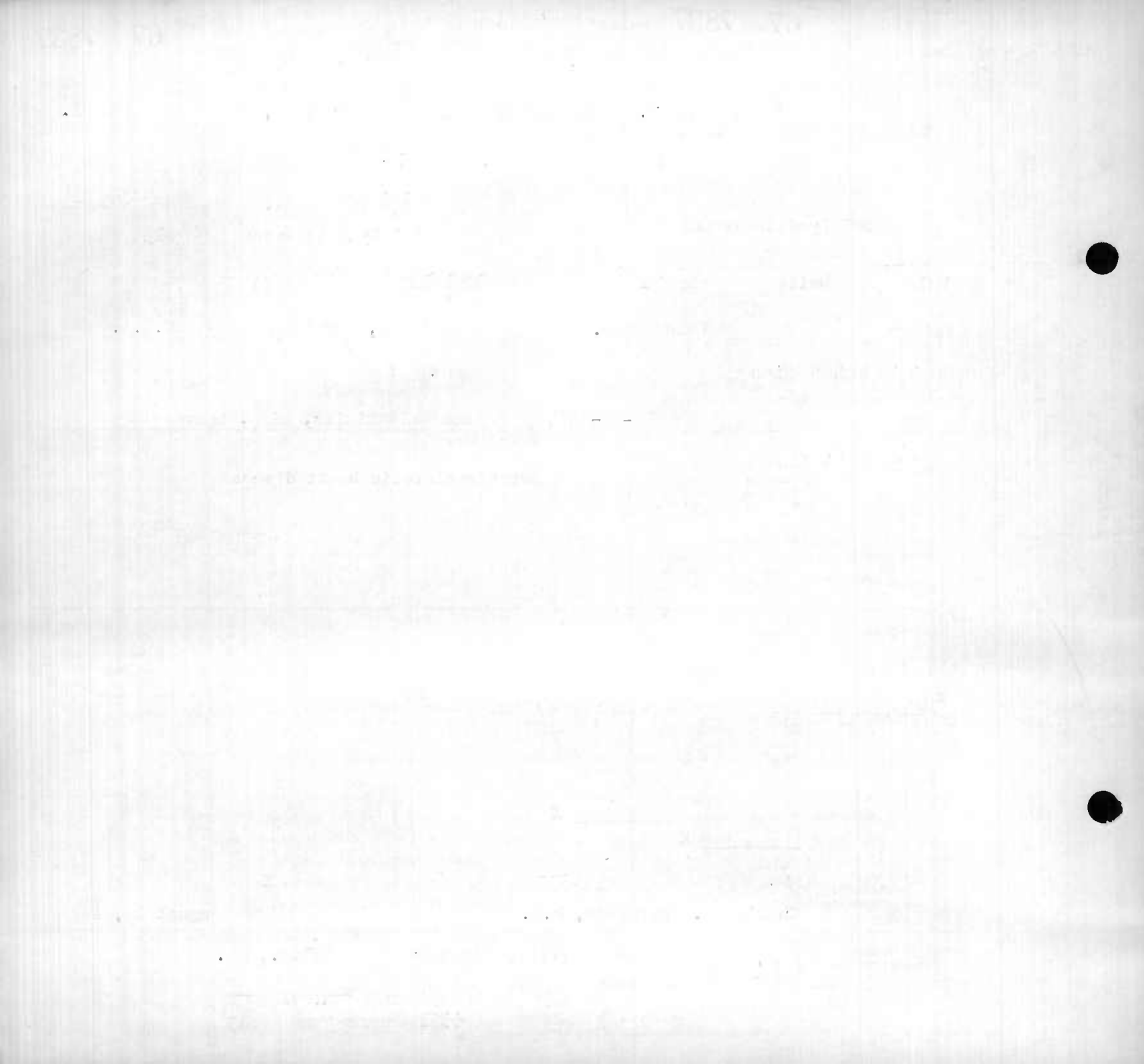
Robert E. Faldut

24C. NAME

Schimunek Funeral Home

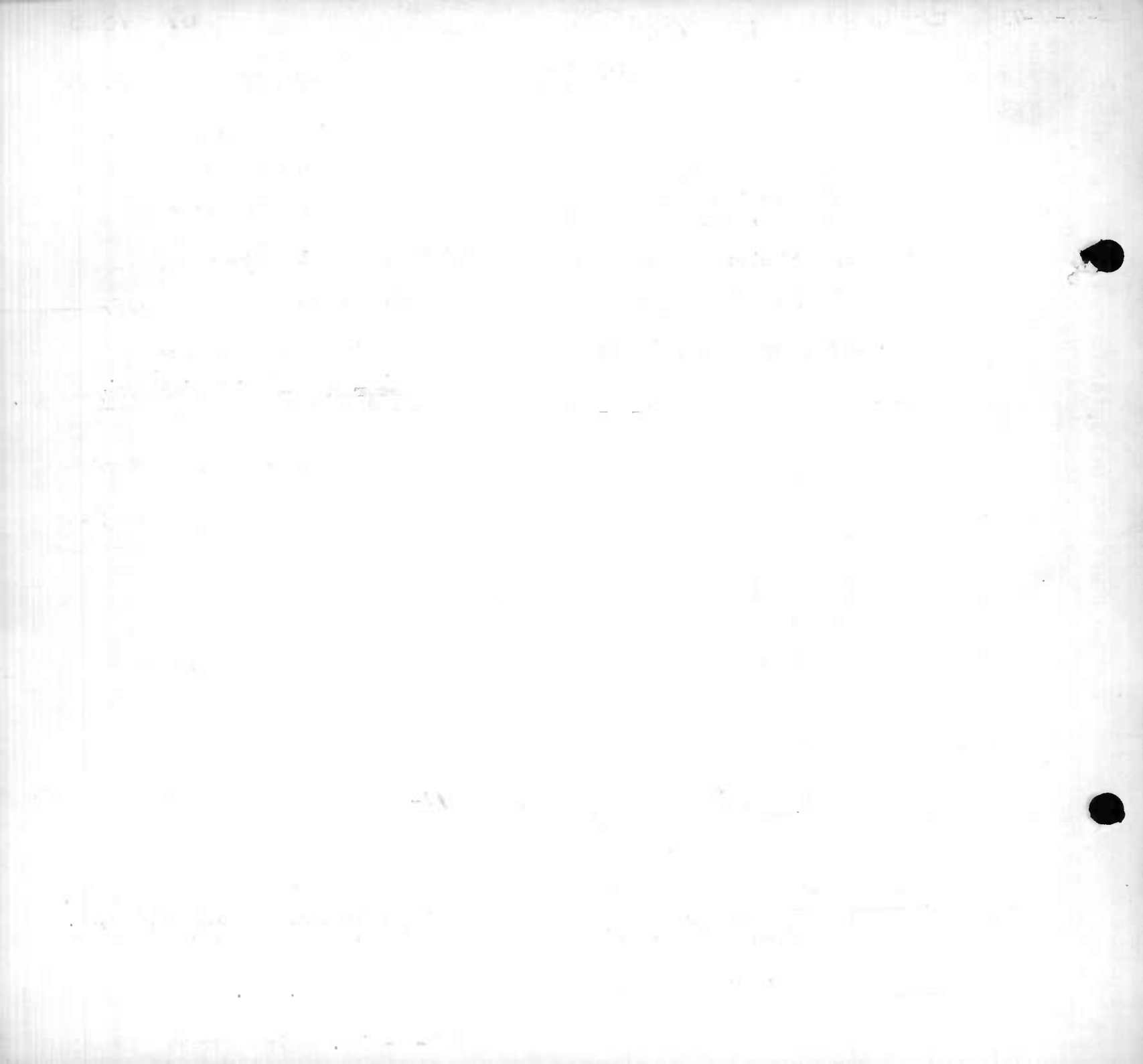
3331 Brehms Lane #13

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-634 67 7838		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7838	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Caroline BARTHOLOME CAROLINE		2. DATE AND HOUR OF DEATH 8/12/67 10:10 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 21205		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7-02	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 625 N. BERNARD AVE #5			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 4/17/76	9. AGE (In years last birthday) 91 91y0	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) AUSTRIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles FISCHER (DECEASED)		14. MOTHER'S MAIDEN NAME ? DECEASED	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-18-9089		17. INFORMANT Frank Bartholme son, 630 E. Streeper Records: BCH-4940 Eastern Avenue OLD CHART. 21224 St.	
18. 194 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PAPILARY ARTERIOCA. DILATION DUE TO (B) I. METHAMPH. IN NEUR. DUE TO (C) 44 years. NO		INTERVAL BETWEEN ONSET AND DEATH 1 year.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/14 19 67 to 8/12 19 67 , that (I) (we) last saw the deceased alive on 8/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jack Brandes		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/67	
23C. PHYSICIAN'S NAME (Type) Jack Brandes		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BALTIMORE CITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/67		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Bal to., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967			
25B. NAME OF REGISTRAR R. P. H. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek, Funeral Home		ADDRESS 2601-03-05 E. Madison Street #5	



1
N-635

67 7839

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7839

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM NORTHAM

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1967

3:50 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ocean City,

D. STREET ADDRESS (If rural, give location)

Box 252

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 26, 1936

9. AGE (In years
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Candy

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Milbur Northam

14. MOTHER'S MAIDEN NAME

Susie Griffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

War 11

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Northam Ocean City, Md.

18.

E 8/19/67

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-11-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Neck operation

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

highway

21C. WHERE DID
INJURY OCCUR?(If in Baltimore City, give exact location)
State route 376 - 8.10 of a mile
east of Berlin, Md.21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 9 67 4:00 A.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto-fixed object collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 20, 1967

23C. NAME of CEMETERY or CREMATORY

Hall Cem.

23D. LOCATION

(City, town, or county)

(State)

Parksley, Accomack, Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1967

24B. NAME OF REGISTRAR

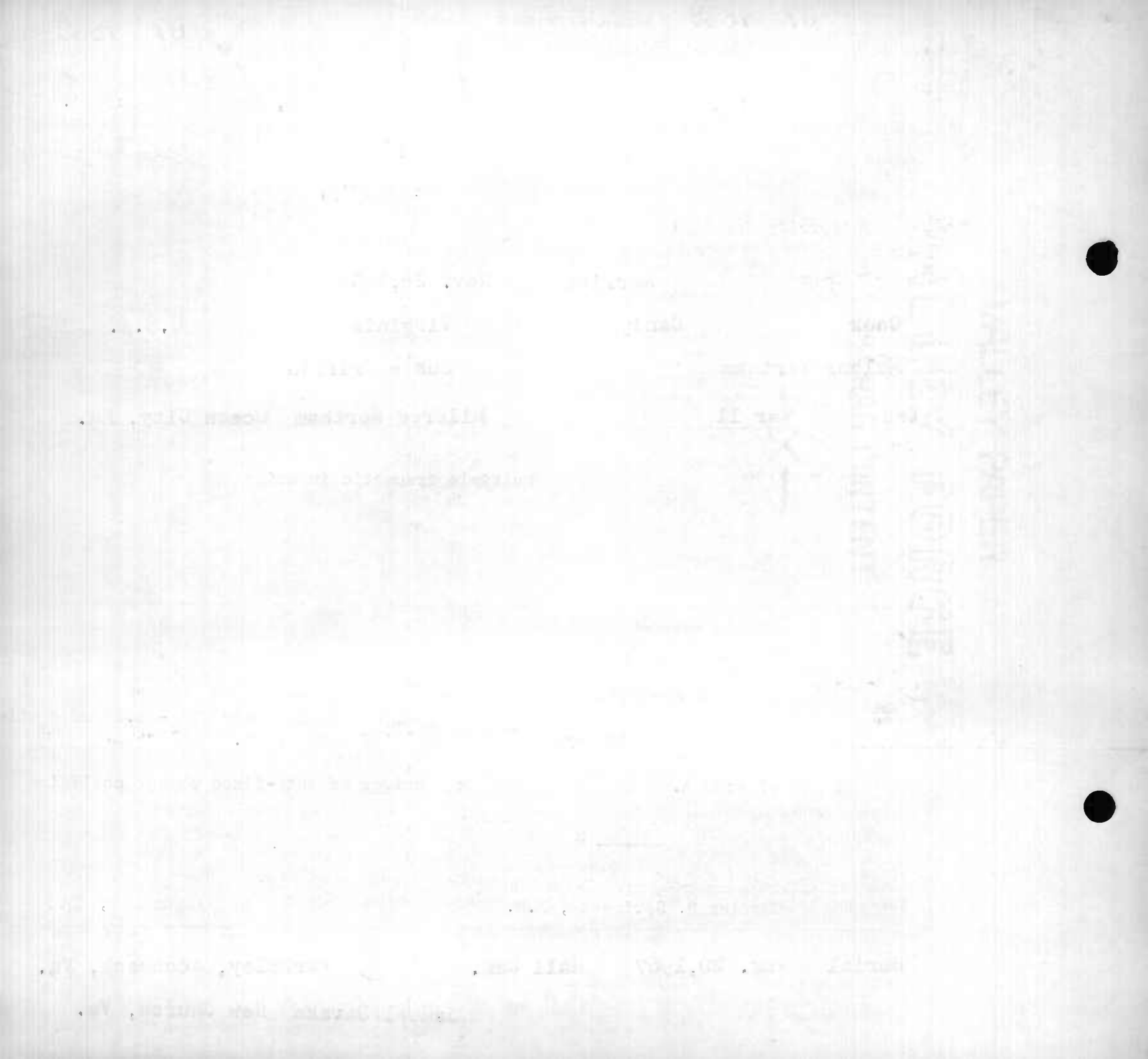
Robert E. Fink

24C. FUNERAL DIRECTOR

Samuel Savage

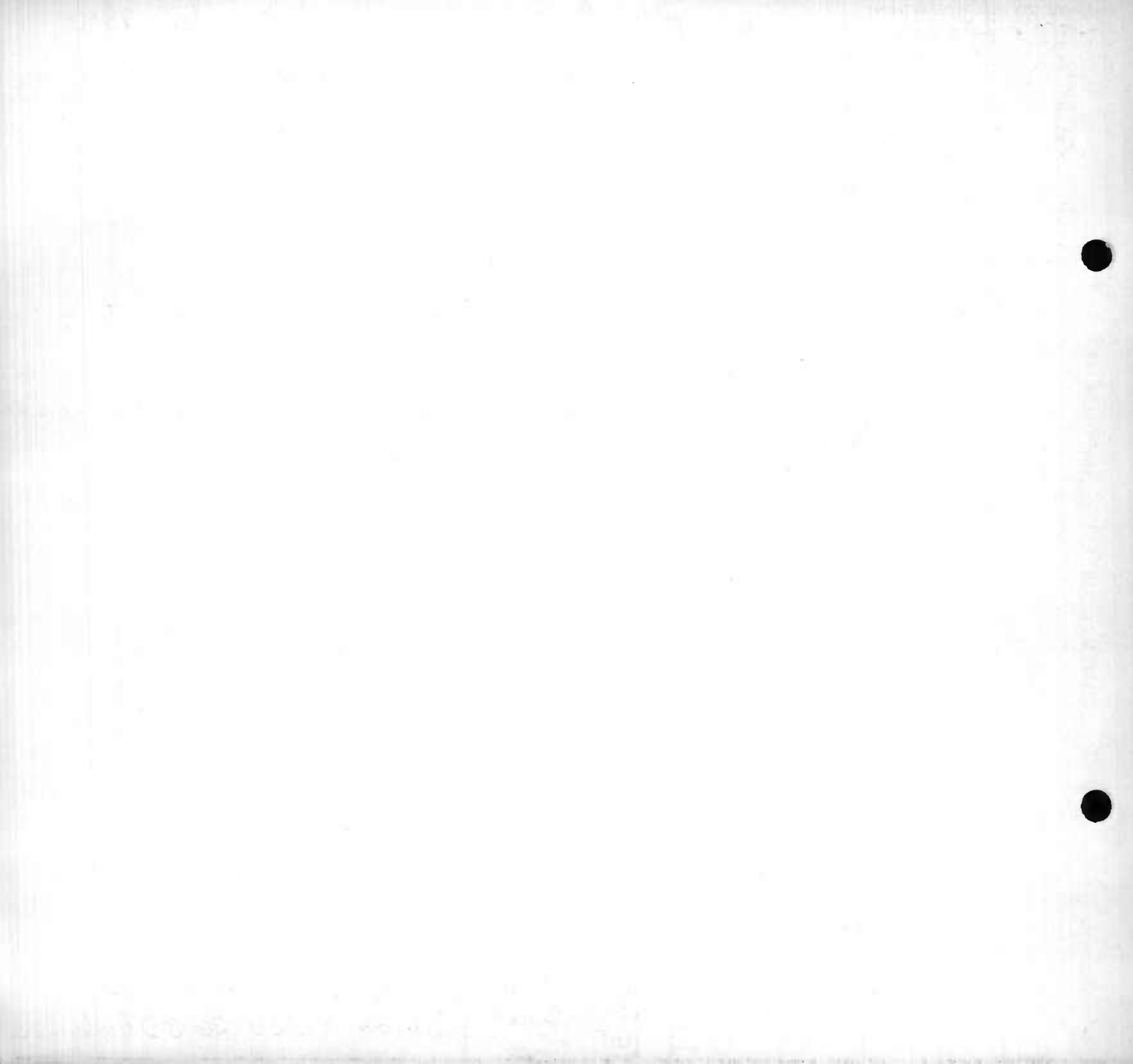
ADDRESS

New Church, Va.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

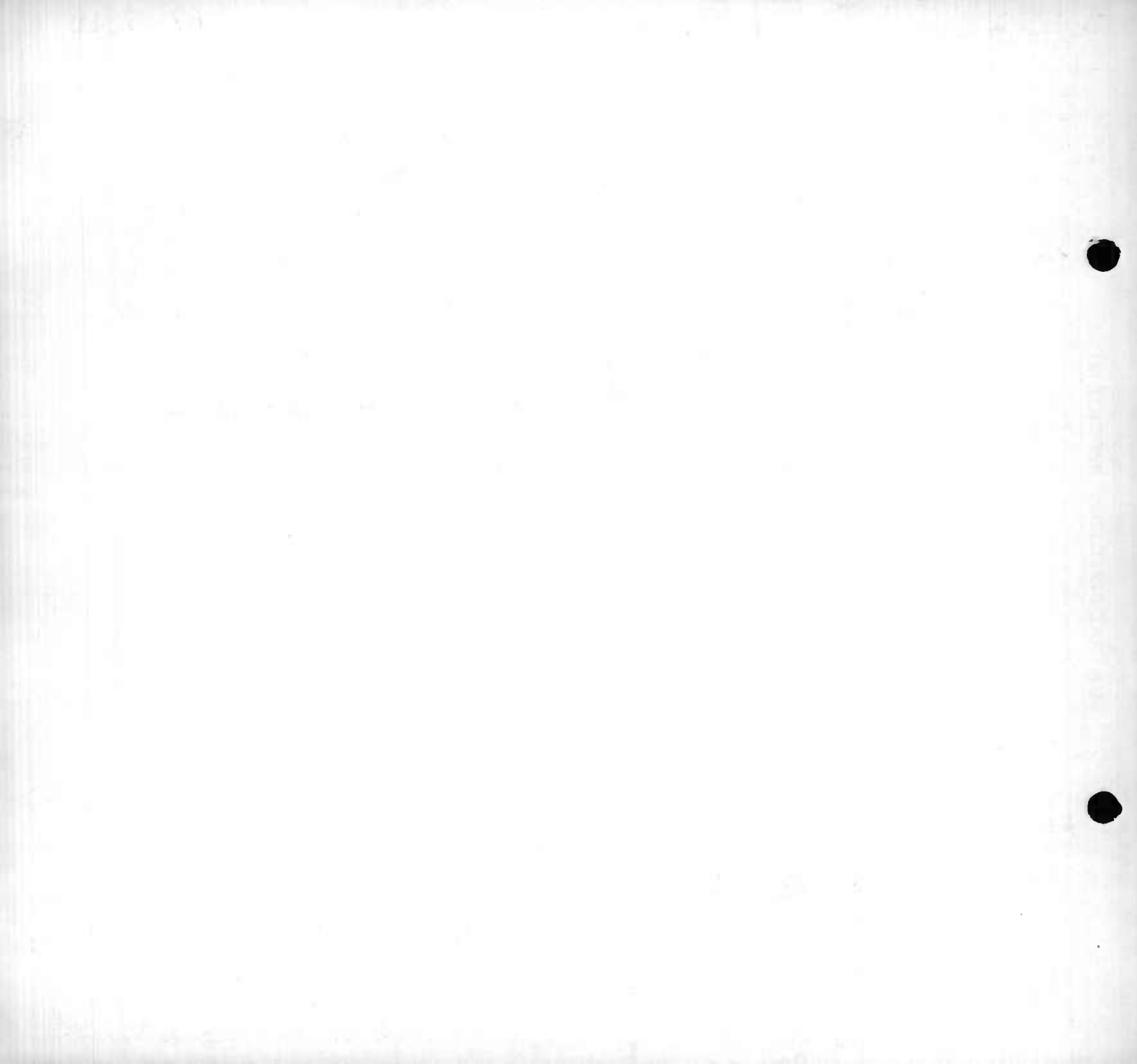
BIRTH NO. 67 7840				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7840	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				CLARK, PEARL G		8/15/67 1.45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
LUTHERAN HOSPITAL				Md.			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
F				C		M	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				—		VA.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Horton				Bettie Scott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
—				217-541712		Lloyd A. Clark 1619 Westwood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1561 I				Acute hepatic failure		days	
ANTECEDENT CAUSES				(B) DUE TO		months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cancer of the liver			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/3 1967 to 8/15 1967, that (I) (we) last saw the deceased alive on 8/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
F. Queral						8/15/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FERNANDO QUERAL				LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug 18, 67		Int. Auburn Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1967		Robert E. Hall		Wilton Webb		3613 Denny Ln Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7841		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7841	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <i>Louise Ogle Dennis</i>				2. DATE AND HOUR OF DEATH <i>8-13-67</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
<i>00 5316 Gwynn Oak Ave</i>				C. CITY OR TOWN <i>BALTO</i>		(If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS <i>5316 Gwynn Oak Ave</i>		(If rural, give location)	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i> <i>DIVORCED</i>	8. DATE OF BIRTH <i>July 24, 1892</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>HARRY Hayden Ogle</i>			14. MOTHER'S MAIDEN NAME <i>Phelps</i>			ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>813-18-7738A</i>		17. INFORMANT <i>GEORGIE CARROLL - Same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Choroid melanoma with metastasis.</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO <i>Hiatus Hernia</i> <i>2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) _____			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 28, 1966</i> to <i>Aug. 13, 1967</i> , that (I) was last saw the deceased alive on <i>Aug. 13, 1967</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was <i>did</i> (did not) view the body after death.							
23A. SIGNATURE <i>Earl L. Chambers</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/15/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Earl L. Chambers</i>				23D. ADDRESS <i>4108 Liberty Hts Balto - Ind</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-16-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>ELSWORTH ARMACOST</i>		ADDRESS <i>4600 Liberty Hts</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7842		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7842	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARDESTER, WILLIAM Sr		2. DATE AND HOUR OF DEATH August 15, 1967 1:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home + Hosp.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1108 Beach Dr. 2120	
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-13-94	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10B. KIND OF BUSINESS OR INDUSTRY Huchster		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christopher Hardester		14. MOTHER'S MAIDEN NAME Emma Hamilton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-1134A		17. INFORMANT ADDRESS Elvira Hardester (wife) same	
18. 15-6-1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Hepatic Insufficiency DUE TO		3 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hepatic malignancy ?? DUE TO		unknown	
(C)		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic heart disease			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <u>hospital</u>) attended the deceased from <u>July 27</u> 19 <u>67</u> to <u>Aug. 15</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 15</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henrietta Suarez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-15-67	
23C. PHYSICIAN'S NAME (Type) HENRIETTA L. SUAREZ		23D. ADDRESS Church Home + Hosp.			
24A. BURIAL REMOVAL (Specify) Burial		24B. DATE 8-18-1967		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore Co.		(City, town, or county)		(State) Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Lashawn Funeral Home 7401 Belair Road	
ADDRESS 36					

Admission 2000

11

Self support

Admission 2000

Admission 2000

6-12-74

Self support

124

Admission 2000

Admission 2000

Admission 2000

Admission 2000

Admission 2000

Aug 21

Aug 21

Aug 21

Admission 2000

Admission 2000

Admission 2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7843	
BIRTH NO. 67 7843		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Leonard C. Lister		8-13-67 10:10 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		Baltimore	
35 Church Home Hospital		D. STREET ADDRESS (If rural, give location)		2610 110 S. Clinton Street	
6. SEX	7. RACE	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	9. DATE OF BIRTH	10. AGE (In years lost birthday)	11. If Under 1 Yr. Months Days
M	W	Married	4-II-1919	48	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country)	
Education Board		Balto, City		Baltimore, Maryland	
15. FATHER'S NAME		16. MOTHER'S MAIDEN NAME		17. CITIZEN OF WHAT COUNTRY?	
Nicholas Lister		Frances Pietzak		U.S.A.	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS	
WWII		217-07-2906		Dorothy Lister 110 S. Clinton Street	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		22. CAUSE OF DEATH		23. INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		MYOCARDIAL INFARCTION			
ANTECEDENT CAUSES		ARTERIOSCLEROTIC CARDIOVASC. DIS.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		PREMATURE VENTRICULAR BEATS			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No)	
0				NO	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED		32. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
33. I certify that (I) (this hospital) attended the deceased from 1966 to JULY 31 1967 , that (I) (we) last saw the deceased alive on JULY 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
34. SIGNATURE				35. DATE SIGNED	
A. E. WALSH				8-14-67	
36. PHYSICIAN'S NAME (Type)		37. ADDRESS			
A. E. WALSH		715 N. CHARLES			
38. BURIAL CREMATION, REMOVAL (Specify)		39. DATE		40. NAME OF CEMETERY OR CREMATORY	
Burial		8-17-67		Gardens of Faith	
41. DATE REC'D BY HEALTH DEPT.		42. NAME OF REGISTRAR		43. FUNERAL DIRECTOR ADDRESS	
AUG 16 1967		Robert E. [Signature]		Walter Dabrowski 1005 Dundalk Avenue	

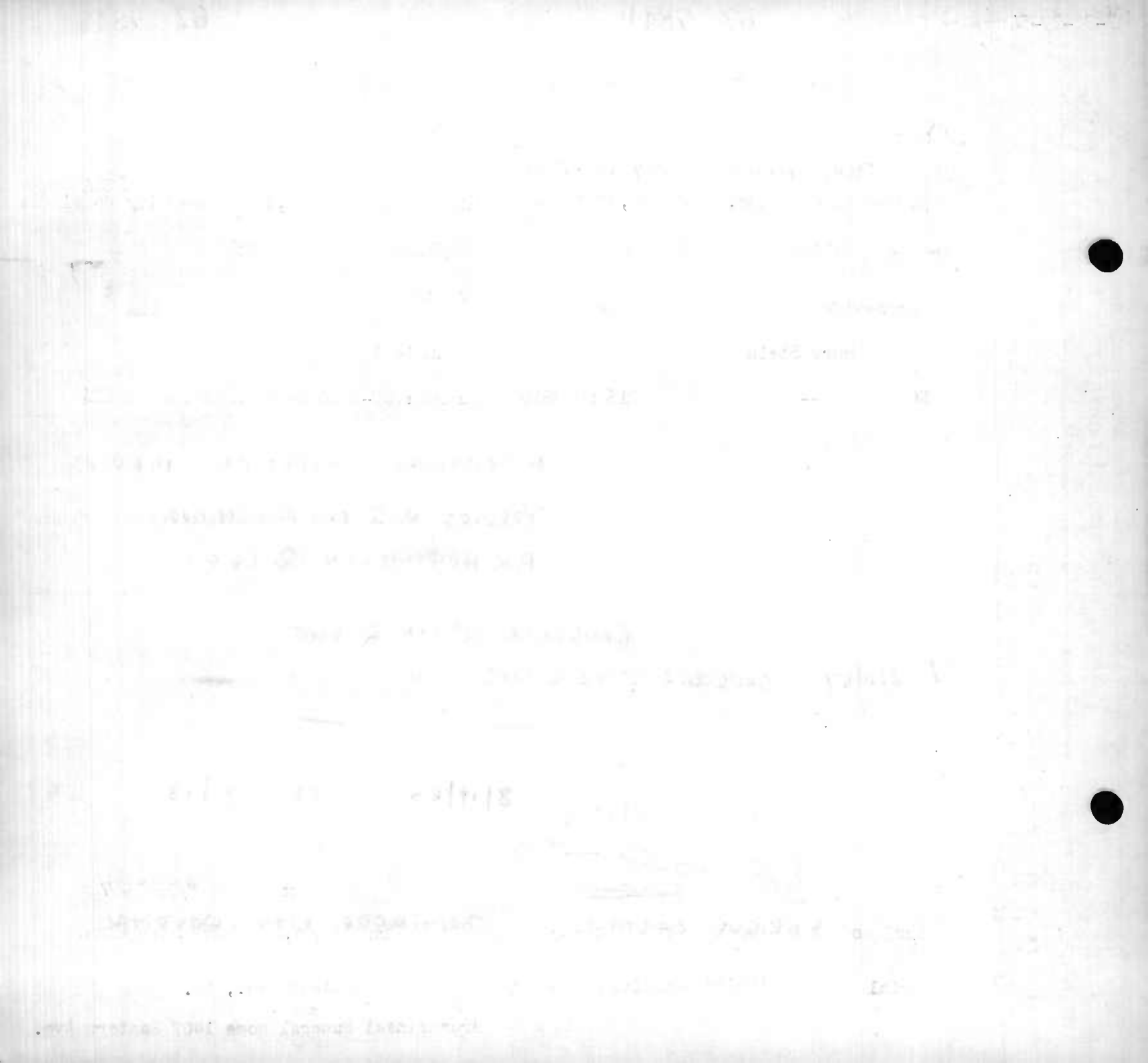
RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

EX-100-1-10

100-1-10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7844	
BIRTH NO. 5-430 67 7844		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCHULTZ ANNIE W.		2. DATE AND HOUR OF DEATH 8/13/67 1 5 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITAL 4940 Eastern Avenue, Baltimore, Maryland		A. STATE Maryland B. COUNTY			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 9/26/1891		9. AGE (In years last birthday) 75		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Stein		14. MOTHER'S MAIDEN NAME Annie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 216 09 7610		17. INFORMANT ADDRESS Records: BCM-4940 Eastern Avenue 21224	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) MYOCARDIAL INFARTION DUE TO		MINUTES	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PREVIOUS M.I AND ARTERIO SCLEROSIS DUE TO		3 months ago.	
		(C) BK AMPUTATION @ LEG			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		GANGRENE 2 ^d TOE @ FOOT			
19A. DATE OF OPERATION 8/11/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE 2 ^d TOE @ FOOT		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/14/63 1963 to 8/13 1967, that (I) (we) last saw the deceased alive on 8/13/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Enrique Castro		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/13/1967	
23C. PHYSICIAN'S NAME (Type) Enrique ENRIQUE CASTRO Castro		23D. ADDRESS BALTIMORE CITY HOSPITAL 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore Co., Md.		24E. NAME OF REGISTRAR		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Prudzenski Funeral Home 1407 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7845		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7845	
M.E. CASE NO. (BARTASAVICH)		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BARTOSZENICK MELVINA J.		2. DATE AND HOUR OF DEATH 8.14.67 4 p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital		A. STATE MD B. COUNTY Balto. Co			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227 53-00			
		D. STREET ADDRESS (If rural, give location) 1230 VOGT AVE			
5. SEX F.	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WID.	8. DATE OF BIRTH 6.17.87	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Max B. Barton - 1230 Vogt Ave	
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Bilateral pneumonia		INTERVAL BETWEEN ONSET AND DEATH 7 days.	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A.S.C.V.D. with atrial fibrillation and uncorrected aortic stenosis.				4 minutes.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7.4.1967 to 8.14.1967, that (I) (we) last saw the deceased alive on 8.14.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nicholas Radotkovic		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8.14.67	
23C. PHYSICIAN'S NAME (Type) MILOS RADOTKOVIC		M.D.		23D. ADDRESS Lutheran Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION Balto. Ind.		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1967		24F. NAME OF REGISTRAR Robert E. Fisher, MA	
24G. FUNERAL DIRECTOR John J. Cowan & Son Inc.		24H. ADDRESS 901 23rd St.			

1
L-526

67 7846

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7846

BIRTH NO.

M.E. CASE NO.

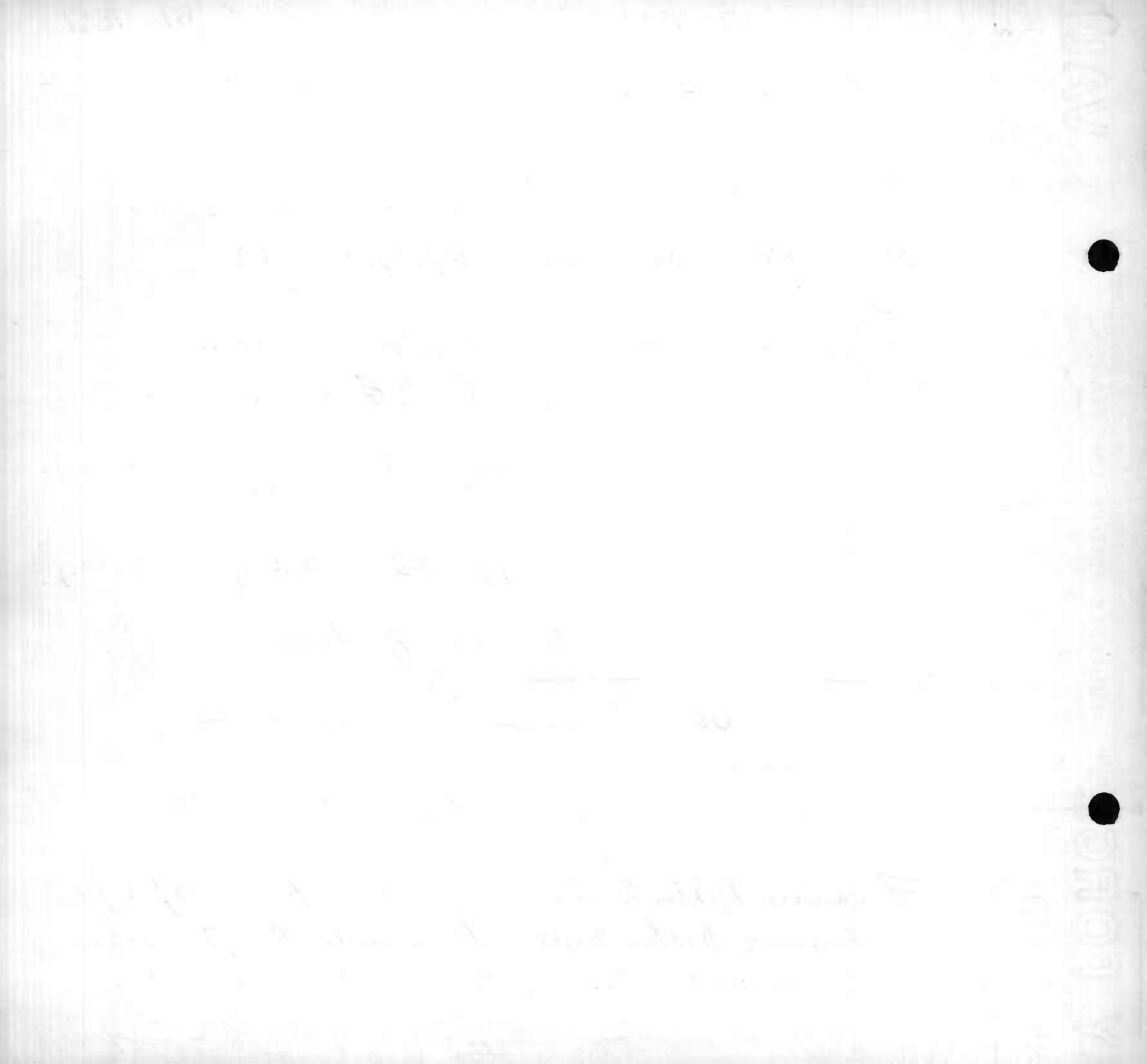
1. NAME OF DECEASED (Type or Print) CHARLES M. LANGREHR				2. DATE AND HOUR PRONOUNCED DEAD August 15, 1967 7:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1831 S. Charles St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 24, 1903	9. AGE (In years last birthday) 64	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Ship Building		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) DUE TO (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8 18 67		23C. NAME of CEMETERY or CREMATORY Glen Haven		23D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		24B. NAME OF REGISTRAR Robert E. Faderman		24C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave	

WALTON (1905)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7847				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7847	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Charles C. Corcoran</i>				2. DATE AND HOUR OF DEATH <i>12 Aug '67 1 73' A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University of Md. Hospt.</i>				A. STATE <i>Md</i> B. COUNTY <i>Howard</i> <i>Howard Co</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Aberdeen</i> <i>62-28</i>			
				D. STREET ADDRESS (If rural, give location) <i>2208 Cedar Lane</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>11/18/03</i>		9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self Emps.</i>		11. BIRTHPLACE (State or foreign country) <i>New York City</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Corcoran</i>				14. MOTHER'S MAIDEN NAME <i>Wilhelmina Jordan</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>117-07-9260</i>		17. INFORMANT <i>Charlotte Corcoran - same as above</i>		ADDRESS	
18. <i>578X I</i> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>From negative sepsis</i> DUE TO <i>as yet unknown organism</i>		<i>2 days</i>	
ANTECEDENT CAUSES				(B) <i>upper GI bleeding</i> DUE TO		<i>8 days</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>cinch of liver</i>		<i>?</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>8/5</i> 19 <i>67</i> to <i>8/12</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>8/12</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Francis Dalton Drake</i> M.D.				23B. DATE SIGNED <i>8/12/67</i>		23C. PHYSICIAN'S NAME (Type) <i>Francis Dalton Drake</i> M.D.	
23D. ADDRESS <i>University Hospt. 21201</i>				23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug-15-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Garden of Faith Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>J. J. Connelley Sons</i>		ADDRESS <i>Essex Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

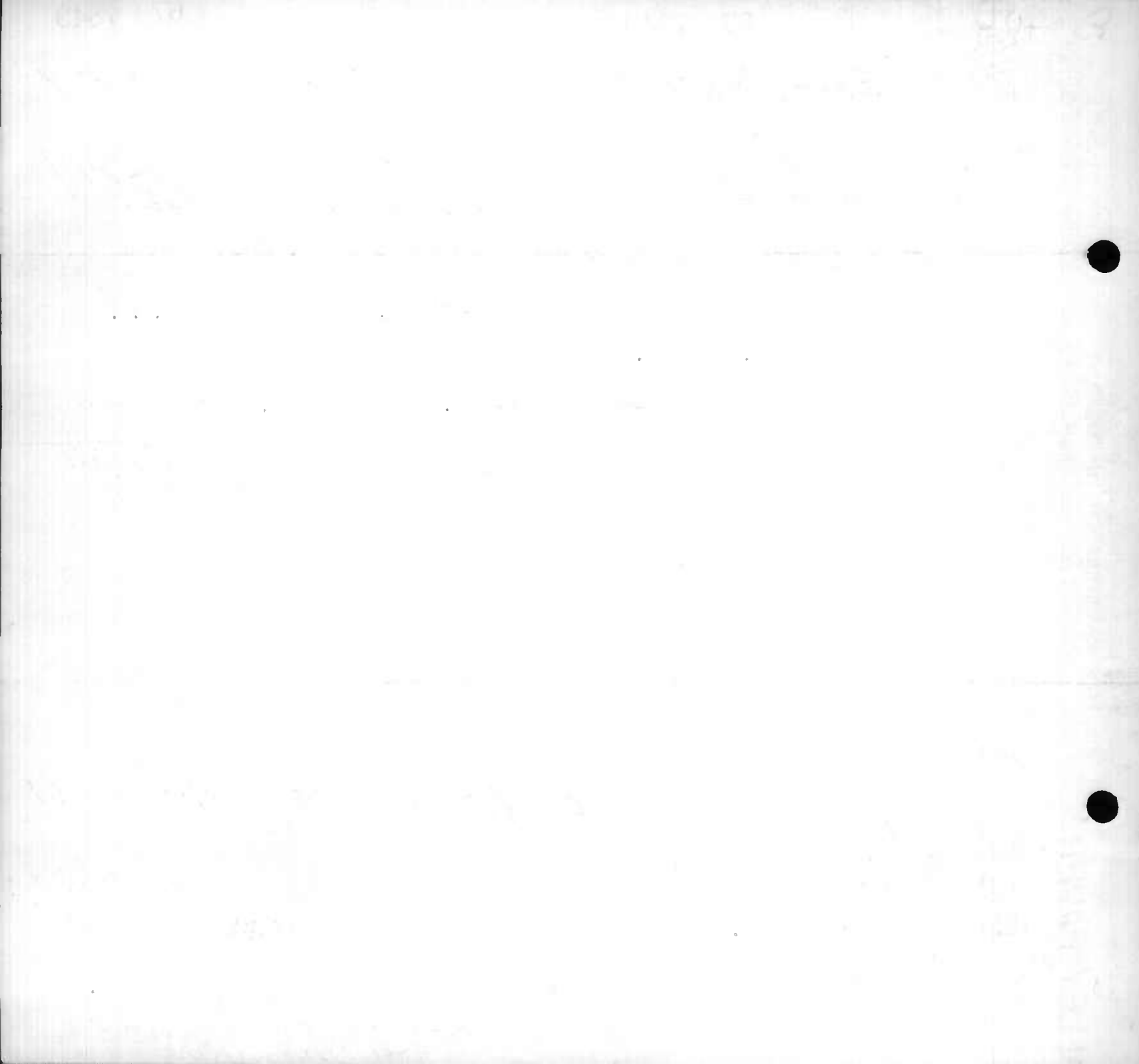
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7848					67 7848				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
ELIZABETH JULIA REYNOLDS					08 15 67 8:20A				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL					A. STATE MARYLAND				
(If not in hospital or institution, give street address or location)					B. COUNTY BALTO.				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
BALTIMORE 21227					3104 ASPEN COURT				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 07 11 10		9. AGE (In years lost birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
SEAMSTRESS		CLOTHING		MARYLAND		U.S.A.			
13. FATHER'S NAME JOSEPH J. House					14. MOTHER'S MAIDEN NAME AUGUSTA ROBERTS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 212 28 118 4				
17. INFORMANT ADDRESS 5 4 ST AGNES HOSPITAL RECORDS									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
260X I					Ante Myocardial infarction				
ANTECEDENT CAUSES					Diabetes Mellitus				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Cardiogenic shock				
II					INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from 8 6 67 to 8 15 1967, that (X) (we) last saw the deceased alive on 8 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
23A. SIGNATURE St Angov George					23B. DATE SIGNED 8-15-67				
23C. PHYSICIAN'S NAME (Type) GEORGE ANGOV,					23D. ADDRESS M.D. ST. AGNES HOSPITAL- BALTO., MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8-18-67		New Cathedral Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS 21229			
AUG 16 1967		Robert E. [Signature]		Howard H. Hubbard,		4107 Wilkens Avenue			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7849		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7849	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) BELL, SARAH H.		
2. DATE AND HOUR OF DEATH 8/13/67 8:39 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
D. STREET ADDRESS (If rural, give location) 2525 W. Belvedere Ave.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOUSE IN THE PINES, BELVEDERE NURSING HOME			
5. SEX F	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 5/20/880	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME David W. Wolff Sr.		
14. MOTHER'S MAIDEN NAME Rebecca Elliott			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-28-4884		17. INFORMANT ADDRESS S. Bradley Bell Jr. 8 1/2 Elmont Avenue 6			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH (A) DUE TO arteriosclerosis & V.D. (B) DUE TO (C) DUE TO 		INTERVAL BETWEEN ONSET AND DEATH 10 Yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28/67 to 8/13/67 , that (I) (we) last saw the deceased alive on 8/12/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman M.D.				23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN		23D. ADDRESS 3700 Park Heights Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-1967		24C. NAME OF CEMETERY or CREMATORY Baltimore, Cemetery	
24D. LOCATION Baltimore City Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR LASSON Funeral Home			
25D. ADDRESS 7401 DENAIR RD.					



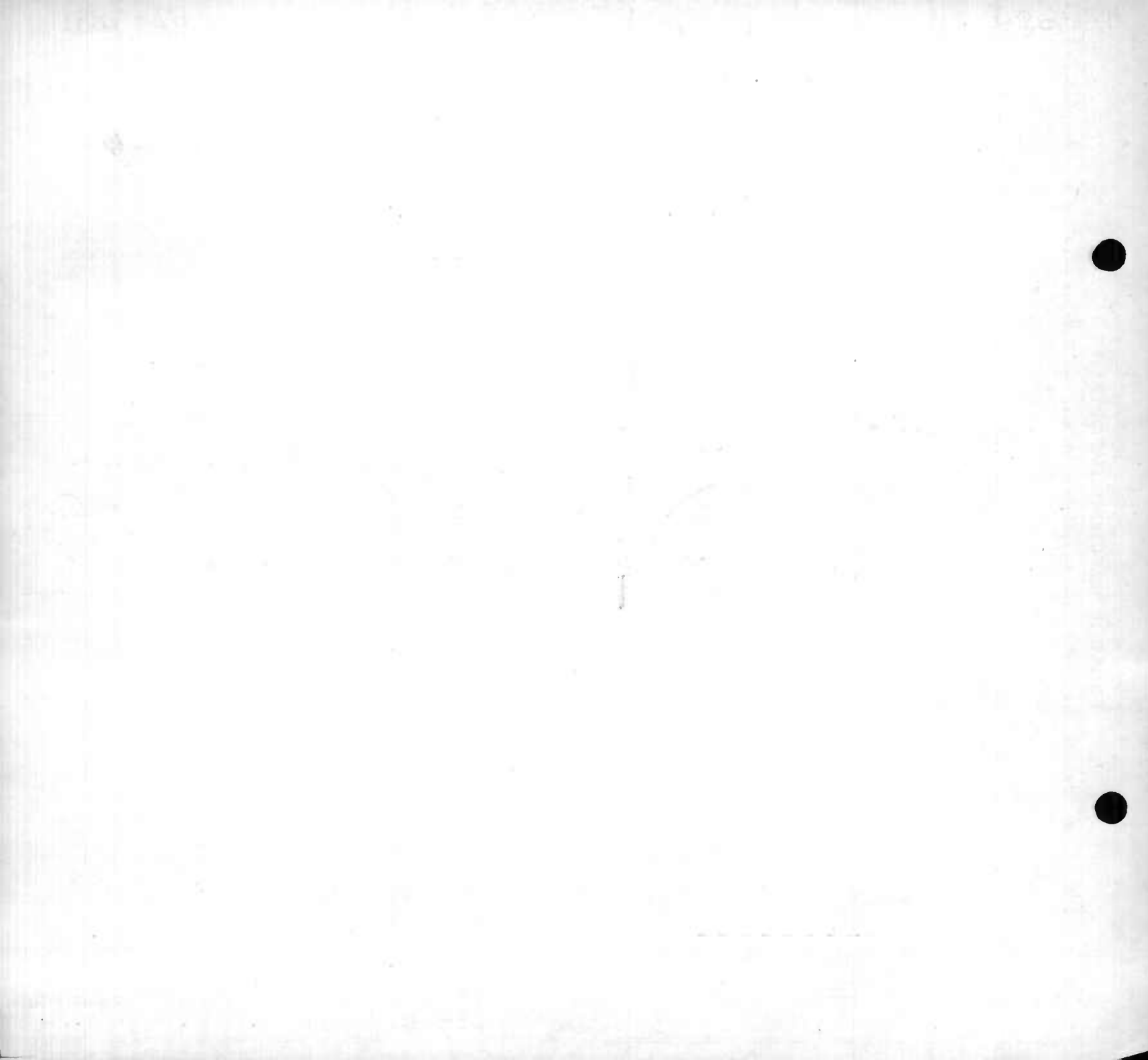
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7850	
BIRTH NO. P-620 67 7850					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Lena POWERS, LINA B.			2. DATE AND HOUR OF DEATH 8-11-67 1 1045A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 4940 Eastern Avenue, Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-36 D. STREET ADDRESS (If rural, give location) 1207 Wohler Way 21224		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-27-94	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days 6 15 If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Warnick		
14. MOTHER'S MAIDEN NAME ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 212-32-2444			17. INFORMANT ADDRESS Records: ECM-4940 Eastern Avenue 21224		
18. CAUSE OF DEATH 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A.S.C.V.D. INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-12-1967 to 8-12-1967 , that (I) (we) last saw the deceased alive on at 1045 8-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Barbu Galin				23B. DATE SIGNED 8-11-67	
23C. PHYSICIAN'S NAME (Type) DR BARBU CALIN				23D. ADDRESS Baltimore City Hospital 4940 Eastern Avenue, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-15-67		24C. NAME of CEMETERY or CREMATORY MT. CARMEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967			
25B. NAME OF REGISTRAR R. E. E. F. J. J.		25C. FUNERAL DIRECTOR ADDRESS Nicholas T. MATTHEWS, 3021 EASTERN AVE.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7851		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7851	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MONAHAN, Mrs. Carrie (CAROLINE McFEE)		2. DATE AND HOUR OF DEATH 8/14/67 13:05 a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 91 JENKINS MEMORIAL HOSPITAL 1000 S. CATON AVENUE BALTIMORE, MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 319 Tuscany Road			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-3-1886	9. AGE (In years lost, birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Merchandising		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James H. Mc Fee		14. MOTHER'S MAIDEN NAME Jennie Bandell (VIRGINIA R.)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 13 10 9153		17. INFORMANT MEDICAL RECORDS ROOM	
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if only giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Cor. arteriosclerosis</i> DUE TO (B) <i>Fx. L hip</i> DUE TO (C) <i>Ch. brain syndrome</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>months</i> <i>years</i>	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel J. Rodriguez</i> J. RAYMOND GLADUE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-14-67	
23C. PHYSICIAN'S NAME (Type) J. RAYMOND GLADUE		23D. ADDRESS Jenkins Memorial- 1000 S Caton Ave. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/67		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1967			
25A. NAME OF REGISTRAR Robert E. Taylor		25B. FUNERAL DIRECTOR Stearns & Mowen Co. 108 W. North Av., City			



FUNERAL DIRECTOR: IMPORTANT

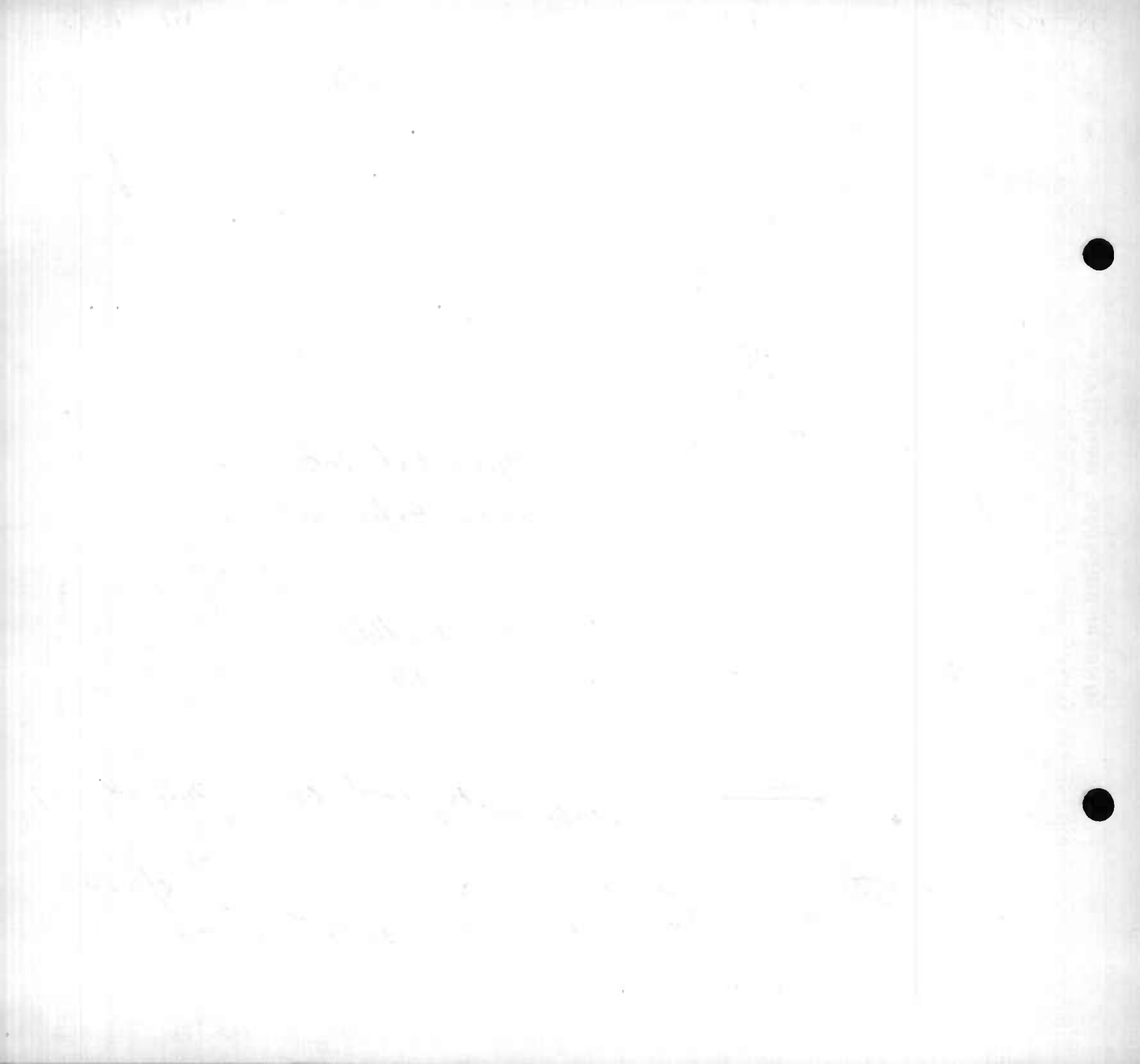
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BIRTH NO.		67 7852		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 7852	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		WILLIAMS MARY L.		8/13/67 4:20 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
THE Union Memorial Hospital		MARYLAND BALTIMORE		BALTIMORE		4402 ROLAND AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
FEMALE	AMERICA	NEVER MARRIED	02-26-79	88 years					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RETIRED-Cataloguer		EPOCH PRATT LIBRARY RETIRED		VIRGINIA-ESSEX Co.		AMERICA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
JUNIOR WILLIAMS		ELLEN PURCELL		NONE		220-44-0240		MRS. MARIE M. TURNER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) HEART DISEASE SMALL BOWEL OBSTRUCTION							
		(B) GENERAL HERNIA with recurrent incarceration							
		(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8/8/67		intestinal obstruction		NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (we) (this hospital) attended the deceased from		8/11/67		1967 to 8/13/67		1967			
that (we) last saw the deceased alive on		8/13/67		1967		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED					
D. Campbell				8/13/67					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
DR. DERMOT CAMPBELL		M.D. THE UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
burial		Aug-15-67		Druid Ridge		Pikesville (21208)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 16 1967		Robert E. Taylor, M.D.		Stewart & Raven Co.		108-W-North-Av 21201			

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7853	
BIRTH NO. 67 7853		CERTIFICATE OF DEATH		Registered No. 67 7853	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ella Neal		2. DATE AND HOUR OF DEATH 8-13-67 1 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto.		C. CITY OR TOWN (If outside city limits, with RURAL and give township) Balto.	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Baltimore, Maryland		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1500 Mountmor Ct.	
5. SEX F	6. RACE Negroid	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 9-30-07	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Peel		14. MOTHER'S MAIDEN NAME Alice Green	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218188456		17. INFORMANT Isabelle Handy 1034 Stricker St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 + 260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Coronary Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White A <input type="checkbox"/> Not White A <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 22nd 1966 to July 2nd 1967, that (we) last saw the deceased alive on July 2nd 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Thompson M.D.		23B. DATE SIGNED 8/15/67		23C. PHYSICIAN'S NAME (Type) Alvin Thompson M.D.	
23D. ADDRESS 1856 N. Wolfe St. Baltimore Md 21213.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-67	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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67 7855 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7855

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DORA

EPPS

2. DATE AND HOUR PRONOUNCED DEAD

August 14, 1967

12:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

515 McMechen Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

515 McMechan St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

9-9-1924

9. AGE (in years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MAXIE EPPS

14. MOTHER'S MAIDEN NAME

MARY MOORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-40-0031

17. INFORMANT

ADDRESS

MARY EPPS 623 PITCHER ST

18.

5-81-0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty Alteration of Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-18-67

23C. NAME of CEMETERY or CREMATORY

MT AUBURN

23D. LOCATION

(City, town, or county)

(State)

BALTO. Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1967

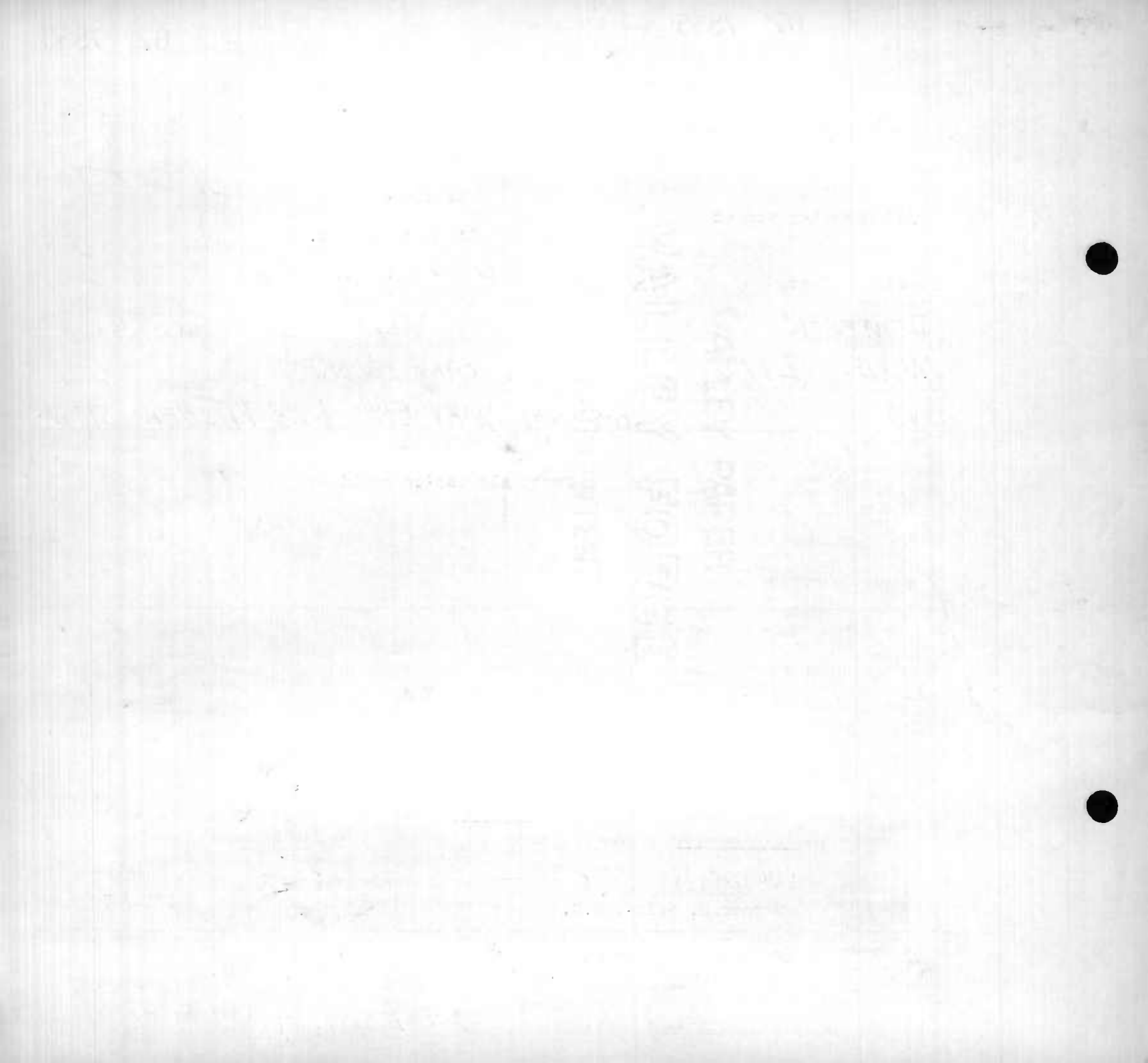
24B. NAME OF REGISTRAR

Joseph E. Spitz

24C. FUNERAL DIRECTOR

JOSEPH BYRNE 1639 N. BROADWAY

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 7856	
BIRTH NO.		67 7856		CERTIFICATE OF DEATH				Registered No. 67 7856			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARET XXXXXXXX M. KNIERIEM		2. DATE AND HOUR OF DEATH 8 15 67				2:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 1 4 90		9. AGE (In years last birthday) 77		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME CHARLES W. Owens				14. MOTHER'S MAIDEN NAME MARY KIGGINS							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSP RECORDS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Pulmonary Embolism Intestinal Obstruction				INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 8/8/1967 to 8/15/1967 that (I) (we) last saw the deceased alive on 8/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Rolando Del Rosario M.D.		23B. DATE SIGNED 8/15/67							
23C. PHYSICIAN'S NAME (Type) ROLANDO DEL ROSARIO		23D. ADDRESS M.D. ST. AGNES HOSPITAL-BALTO., MD. 21229									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-1967		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR R. E. F. Adams		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7857				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7857	
1. NAME OF DECEASED (Type or Print) Stephen J. Berberich				2. DATE AND HOUR OF DEATH 8-15-67 8:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 6-01 D. STREET ADDRESS (If rural, give location) 12 1/2 W. Decker Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 3-25-88	9. AGE (In years last birthday) 79	10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Berberich				14. MOTHER'S MAIDEN NAME Martin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-32-9433		17. INFORMANT ADDRESS Charles M. Berberich 601 Forest View Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Emphysema				CAUSE OF DEATH (A) Myocardial infarction (B) Emphysema (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 27th 1967 to Aug 15th 1967 , that (I) (we) last saw the deceased alive on Aug 15th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D.						23B. DATE SIGNED Aug 15th '67	
23C. PHYSICIAN'S NAME (Type) KYE KOON IKIM M.D.				23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/1967		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS John A. Moran Inc. 3000 E. Baltimore St.			

N 5827

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7858	
BIRTH NO. 67 7858		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH Aug 14, 1967 9:45 A.M.	
1. NAME OF DECEASED (Type or Print) Sherman Meads		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 726 Pacific Street Baltimore, Maryland 21211		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 726 Pacific Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/1/89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker		10B. KIND OF BUSINESS OR INDUSTRY Cotton Mill	9. AGE (In years last birthday) 77 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Benjamin Meads		14. MOTHER'S MAIDEN NAME Carter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W I		16. SOCIAL SECURITY NO. 215-07-6581	
17. INFORMANT Mrs. Sarah Meads		ADDRESS 729 Pacific St. 21211	
18. 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Carcinoma of Bladder INTERVAL BETWEEN ONSET AND DEATH Sudden 5/29/67	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/17 19 61 to 8/14 19 67 , that (I) we lost saw the deceased alive on 8/14 19 67 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.			
23A. SIGNATURE Reuben Hoffman		23B. DATE SIGNED 8-15-67	
23C. PHYSICIAN'S NAME (Type) REUBEN HOFFMAN		23D. ADDRESS 846 W. 36th St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 17, 1967	
24C. NAME OF CEMETERY or CREMATORY St. Marys Cemetery (Hampden)		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR Reuben E. Hoffman	
25C. FUNERAL DIRECTOR Frank W. Seitz		ADDRESS 814 W. 36th St.	

George Washington
Washington of the
1799

George Washington
Washington of the
1799

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

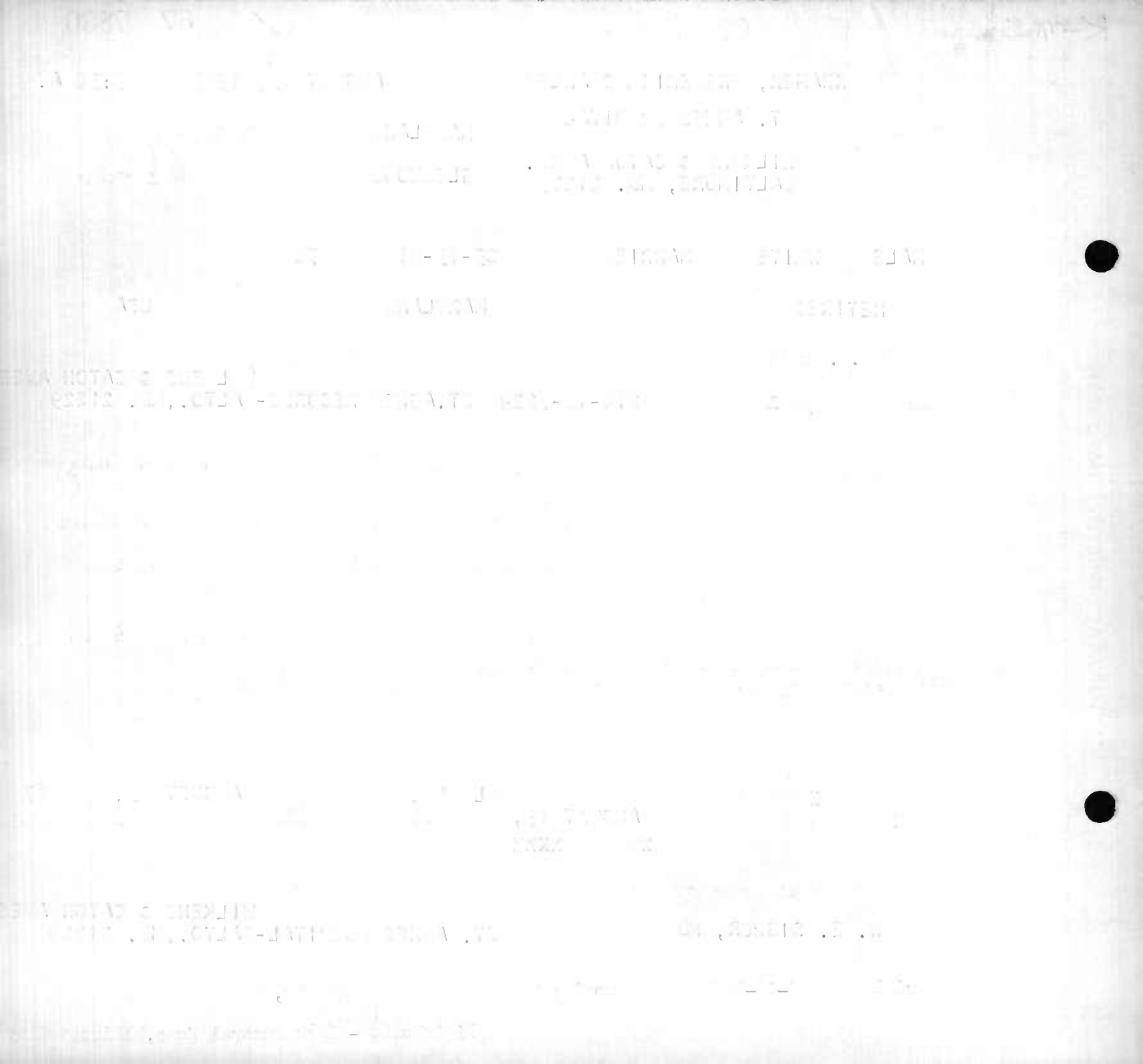
BIRTH NO. 67 7859		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7859	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN F. SCHAEFFER</u>		2. DATE AND HOUR OF DEATH <u>Aug 12, 1967</u> 1 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>	
<u>35 Church Home Hosp</u>		C. CITY OR TOWN <u>Baltimore</u>		<u>53-00</u>	
D. STREET ADDRESS (If rural, give location)		<u>204 BERSHIRE RD</u>			
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-6-1907</u>	9. AGE (In years lost birthday) <u>60 yrs</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>RETIRED JANITOR</u>		<u>AMER CAN</u>		<u>MD</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		<u>JOHN SCHAEFFER</u>		<u>AGUSTA FALK</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5848 10588</u>		17. INFORMANT <u>JOHN J. SCHAEFFER</u> ADDRESS <u>7455 BERSHIRE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO <u>PULMONARY EMBOLISM - 1967</u>			
DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last.		(B) DUE TO <u>COMPLICATING FRACTURE OF RIGHT FEMUR</u>			
		(C) DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>ARTERIOSCLEROTIC HEART DISEASE</u>			
19A. DATE OF OPERATION <u>8-7-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>FRACTURE OF RIGHT FEMUR</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>BAR</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>2304 E. FAIRMOUNT AVE.</u>	
21D. TIME OF INJURY (APPROX.) <u>8-3-67 1030 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>STUMBLER OVER CHAIR AND FELL</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> 19 <u>67</u> to <u>8/12</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8/12</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Veneracion J. Veneracion</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug 12, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>VENERACION</u>		23D. ADDRESS <u>Church Home + Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-16-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST. STANISLAUS</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairman</u>		25C. FUNERAL DIRECTOR <u>W. Kapro Roush</u> ADDRESS <u>5525 Fleet St</u>	

2. AT 17/10/2018 20.28.22 4401

[Faint handwritten signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7860		REGISTERED NO. 67 7860	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) KRAMER, FREDERICK CHARLES				2. DATE AND HOUR OF DEATH AUGUST 13, 1967 7:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION If not in hospital or institution, give street address or location WILKENS & CATON AVES. BALTIMORE, MD. 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD Co. 5. CITY OR TOWN (If outside city limits, write RURAL and give township) GLENWOOD 6. STREET ADDRESS (If rural, give location) 63-00			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 05-13-91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 76		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME FRED. C. KRAMER			
14. MOTHER'S MAIDEN NAME EMMA WOSSOWSKI				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1			
16. SOCIAL SECURITY NO. 214-18-7224				17. INFORMANT WILKENS & CATON AVES ST. AGNES RECORDS-BALTO., MD. 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIOVASCULAR COLLAPSE (B) PULMONARY EMBOLISM (C) DEEP VEIN THROMBOSIS (LEGS)				INTERVAL BETWEEN ONSET AND DEATH 4 HRS. 3 WKS. WKS.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Post Op. STRESS ULCERS (BLEEDING)				5 DAYS.			
19A. DATE OF OPERATION 7/29/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Vena Cava Ligation		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from JULY 24, 19 67 to AUGUST 13, 19 67. that (X) (we) last saw the deceased alive on AUGUST 13, 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.			
23A. SIGNATURE W. E. Signor M.D.				23B. DATE SIGNED 8/13/67		23C. PHYSICIAN'S NAME (Type) W. E. SIGNOR, MD	
23D. ADDRESS ST. AGNES HOSPITAL-BALTO., MD. 21229				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8-16-1967		24C. NAME of CEMETERY or CREMATORY Provident		24D. LOCATION (City, town, or county) (State) Glenelg, Md		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967	
25B. NAME OF REGISTRAR Robert E. Talley, M.D.				25C. FUNERAL DIRECTOR John E. Slack Wigginbotham-Slack Funeral Home, Ellicott City			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 7861		67 7861	
1. NAME OF DECEASED (Type or Print) MILLER HARRY FESSLER				2. DATE AND HOUR OF DEATH 8/12/67 4:12 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL WILKENS AND CATON AVE BALTIMORE MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED				8. DATE OF BIRTH 09 23 06 9. AGE (In years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Work				10B. KIND OF BUSINESS OR INDUSTRY W.J.Dickey	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U SA	
13. FATHER'S NAME BENJAMIN MILLER				14. MOTHER'S MAIDEN NAME RE INCOLLAR EDNA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-09-6163	
17. INFORMANT ST AGNES HOSPITAL WILKENS AVE 21229				ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 9 1967 to AUGUST 12 1967 , that (I) (we) last saw the deceased alive on AUGUST 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Korbuly, M.D. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) SUSAN KORBULY				23D. ADDRESS ST AGNES HOSPITAL WILKENS AVE 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-1967		24C. NAME OF CEMETERY OR CREMATORY Good Shepherd	
24D. LOCATION (City, town, or county) Ellicott City, Md		24E. STATE (State) Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Highbotham-Slack, Ellicott City, Md	

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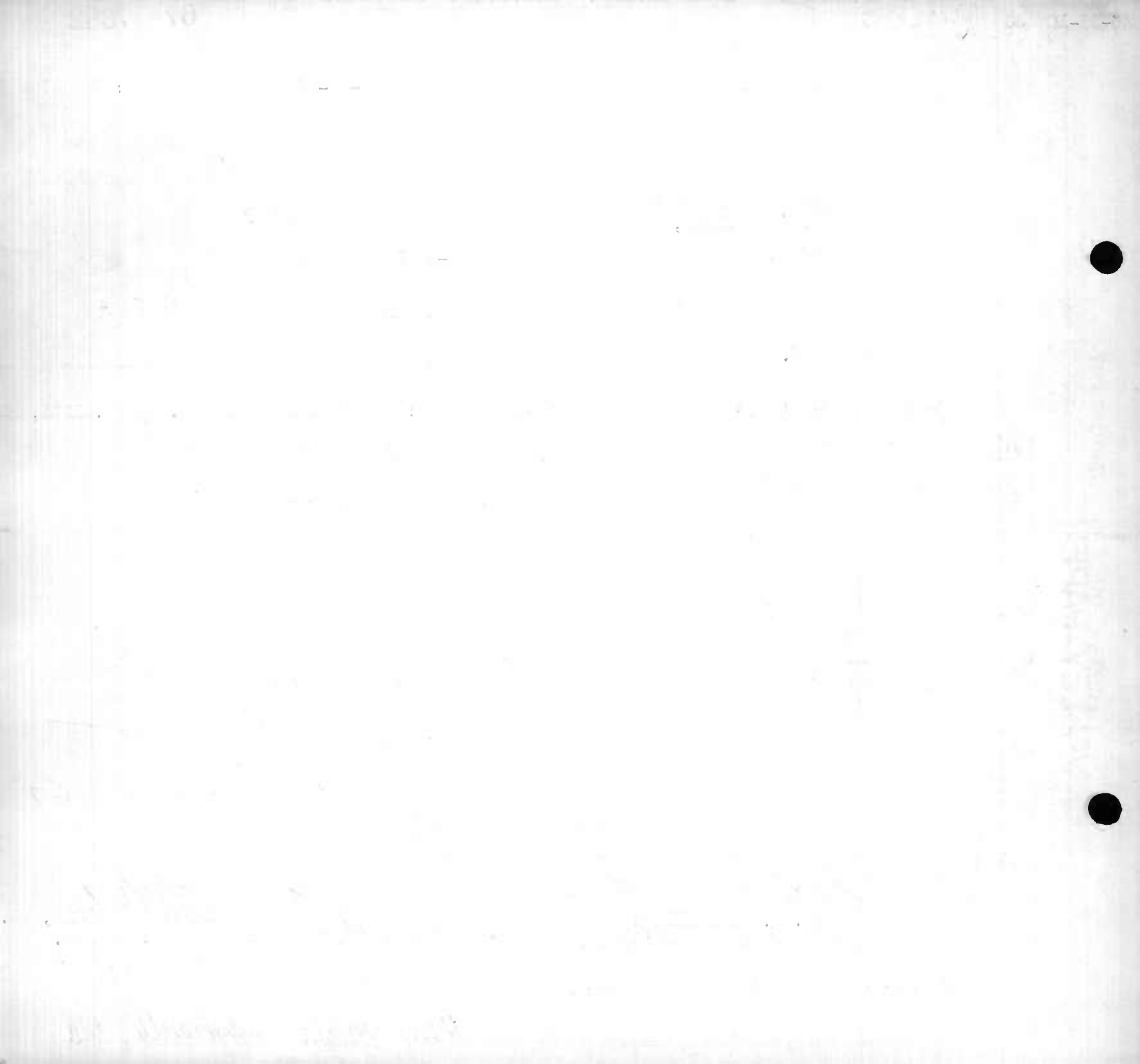
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10/21/50

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 200		67 7862		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7862	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) EUGENE PEACH			
2. DATE AND HOUR OF DEATH 8-11-67 1:45 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODSTOCK		D. STREET ADDRESS (If rural, give location) SUMMIT AVENUE 21163		5. SEX MALE	
6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-27-16		9. AGE (In years lost birthday) 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LITHOGRAPHER Z		10B. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER J.				14. MOTHER'S MAIDEN NAME NORA YOUNG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224, MD.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Embryonal Cell Carcinoma				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/2 19 67 to 8/11 19 67 , that (I) (we) last saw the deceased alive on 8/11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Walter Wilson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/67	
23C. PHYSICIAN'S NAME (Type) DR. W. STAN WILSON				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-15-67		24C. NAME OF CEMETERY or CREMATORY Lake View Cemetery		24D. LOCATION (City, town, or county) (State) Sykesville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Harry Haight		25C. FUNERAL DIRECTOR Sykesville, Md.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7863		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7863	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDMONDS, GEORGE		2. DATE AND HOUR OF DEATH 13 AUG. 1967 1140 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSP GREENE & REDWOOD STS.		D. STREET ADDRESS (If rural, give location) 125, CARLTON ST #23		5. SEX M	
6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 2/24/05	
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Pa., Philadelphia	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY DISABLED		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ROBERT EDMONDS		14. MOTHER'S MAIDEN NAME ANNA COOK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN	
16. SOCIAL SECURITY NO.		17. INFORMANT PATIENT'S CHART.		ADDRESS	
18. 451X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) BILATERAL PNEUMONIA DUE TO (B) DUE TO (C) PULMONARY HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 72-48 hours MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thoracic aneurysm,		19A. DATE OF OPERATION AUG 8, 67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED THORACIC ANEURYSM	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/11/67 19 to 8/13/67 19 that (I) (we) last saw the deceased alive on 8/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Ferdinand S. Leacock M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) FERDINAND SLEACOCK M.D.	
23D. ADDRESS University Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/1967	
24C. NAME OF CEMETERY OR CREMATORY St. Albans Cem., Balto., Md.		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967	
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3197 Schowen St.	

9/4/67 - Thence overgrown due to arteriosclerosis
better from liver. Keep on file. Saw of
Ruth Perkins - American Bible Soc.

ROBERT EDMONDS
DISEASE

ROBERT EDMONDS

ROBERT EDMONDS

8/1/67

8/1/67

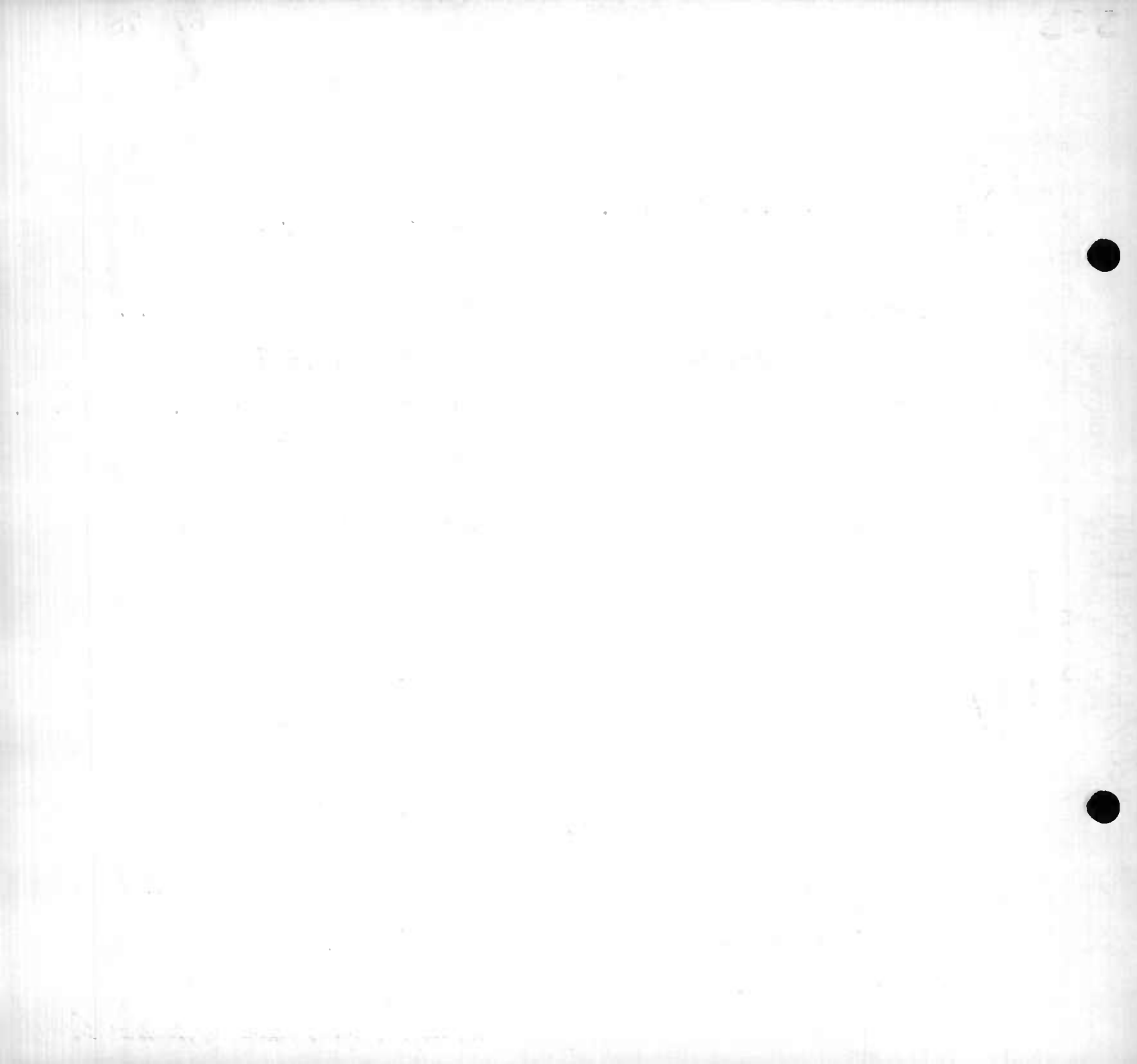
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Thence 2 years

FUNERAL DIRECTOR: IMPORTANT

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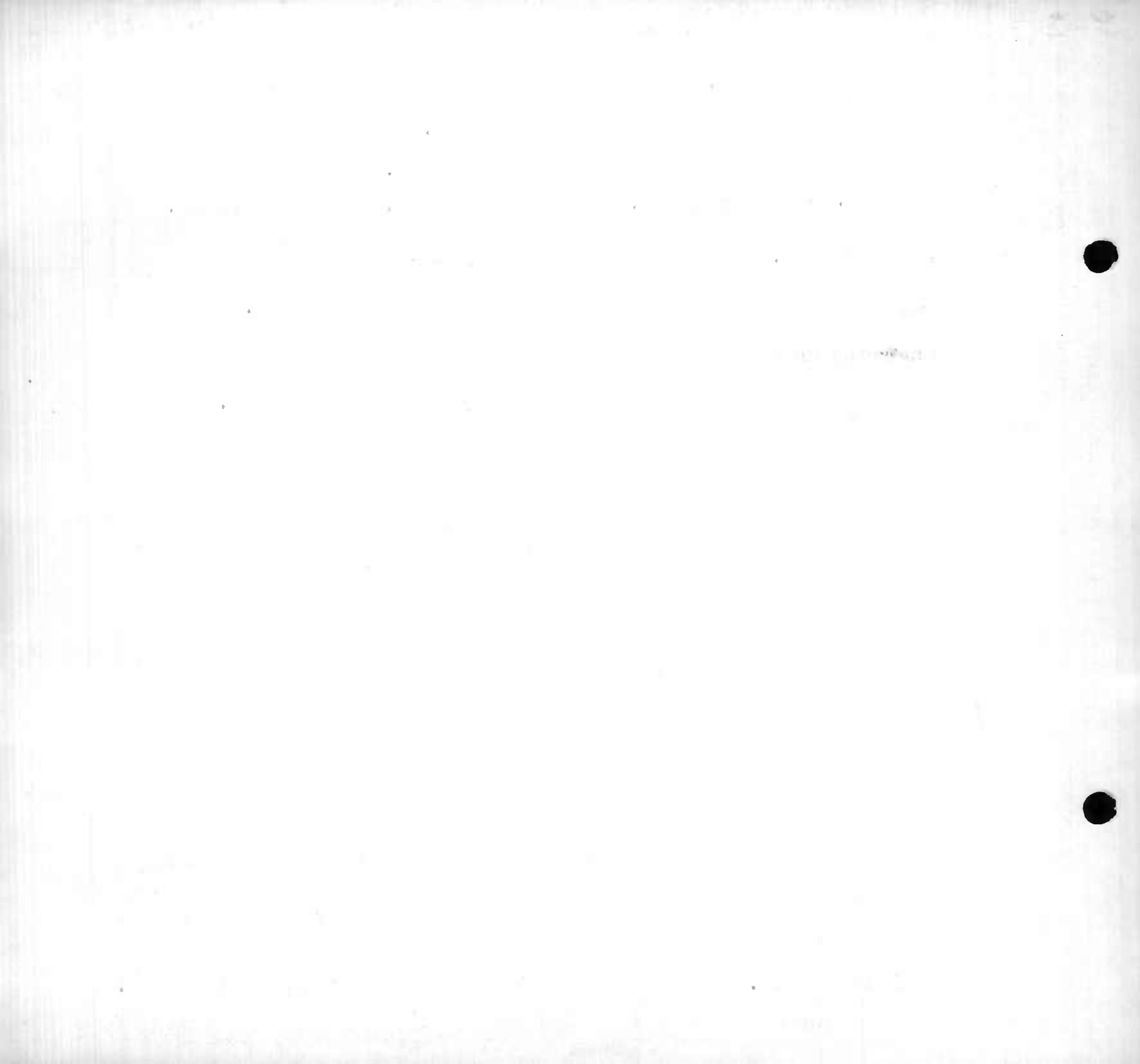
B-500		67 7864		CERTIFICATE OF DEATH		Registered No. 67 7864	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BESSIE BOONE (BESSIE BOONE)		8/15/67 15:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland			
BALTIMORE CITY Hospitals 4940 Eastern Ave. Baltimore, Md. #21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1105 W. Lanvale St. 21217			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired)		
Female	Negro	Never Married	9/10/17	49	Domestic		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				North Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Boone				Virginia Mizett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				BCH: Records 4940 Eastern Ave. Baltimore, Md.		#21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				aplastic anemia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/23 1967 to 8/15 1967, that (I) (we) last saw the deceased alive on 8/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Zachary Grossman M.D.						23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) Zachary Grossman				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City or town or county) (State)	
Burial		8/19/67		Mt Auburn Cem		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1967		Robert E. Fisher, M.D.		Williams Funeral Home		3142 Broadway St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

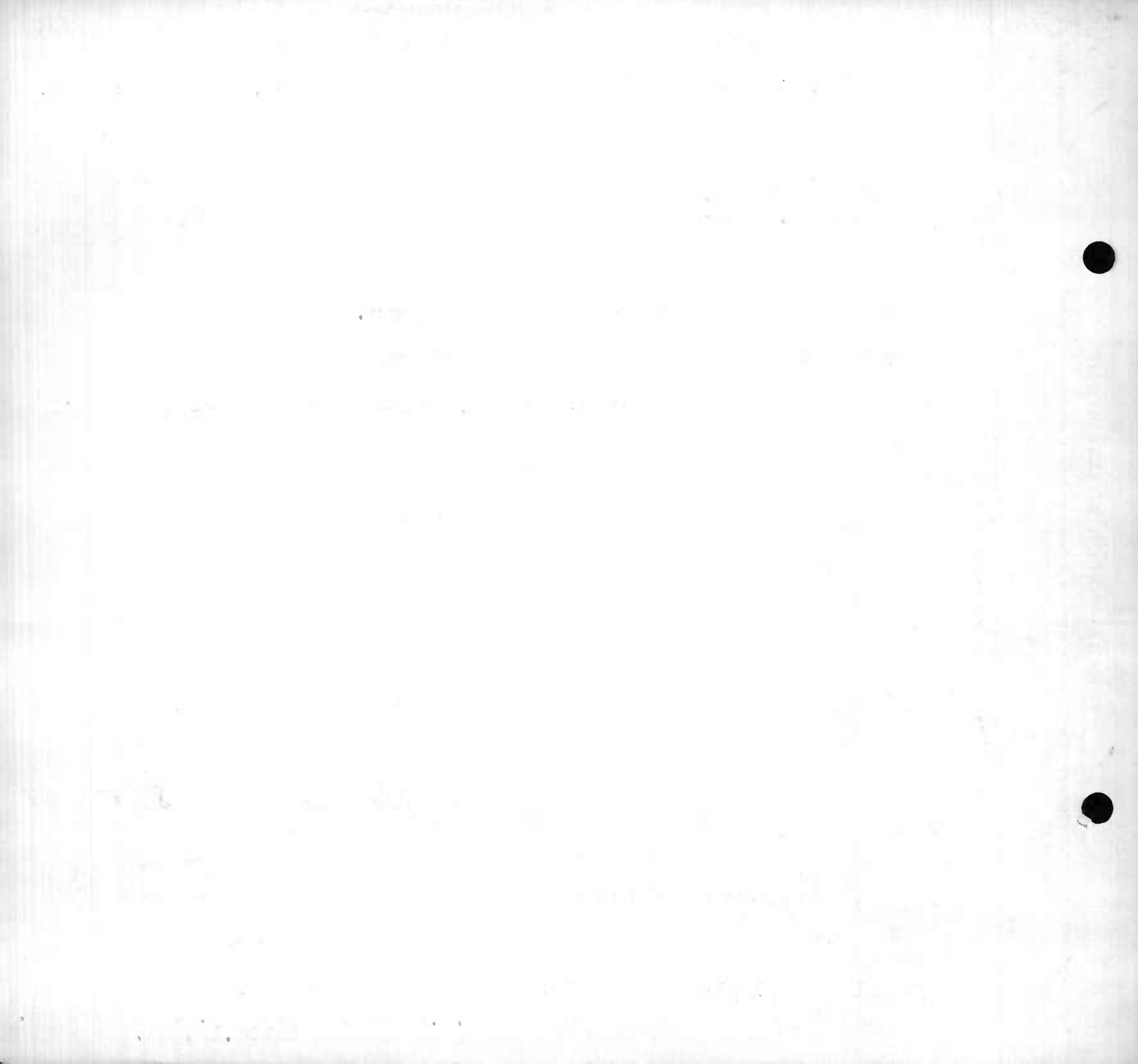
BIRTH NO. 67 7865				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7865	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROSIE E. SMITH				2. DATE AND HOUR OF DEATH AUGUST 12, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00 834 N. Franklinton Rd.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.		D. STREET ADDRESS (If rural, give location) 834 N. Franklinton Rd.	
5. SEX Female	6. RACE Col.	7. MARRIED, NEVER MARRIED Widowed	8. DATE OF BIRTH May 10, 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Taylors Island Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dan Thompson				14. MOTHER'S MAIDEN NAME Hester Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn Coleman		ADDRESS 834 N. Franklinton Rd.	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocardial Insufficiency DUE TO (B) Generalized Arteriosclerosis DUE TO (C) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs 1 yr			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 15 1967 to August 12 1967 , that (I) (we) last saw the deceased alive on August 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marcus W. Moore Sr				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/16/67	
23C. PHYSICIAN'S NAME (Type) Marcus W. Moore Sr				23D. ADDRESS 1371 N. Carey Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 17/67		24C. NAME OF CEMETERY or CREMATORY Lanes Chapel		24D. LOCATION (City, town, or county) (State) Taylors Island Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR William's Funeral Home			
				ADDRESS 319 N. Lorraine St			



FUNERAL DIRECTOR: IMPORTANT

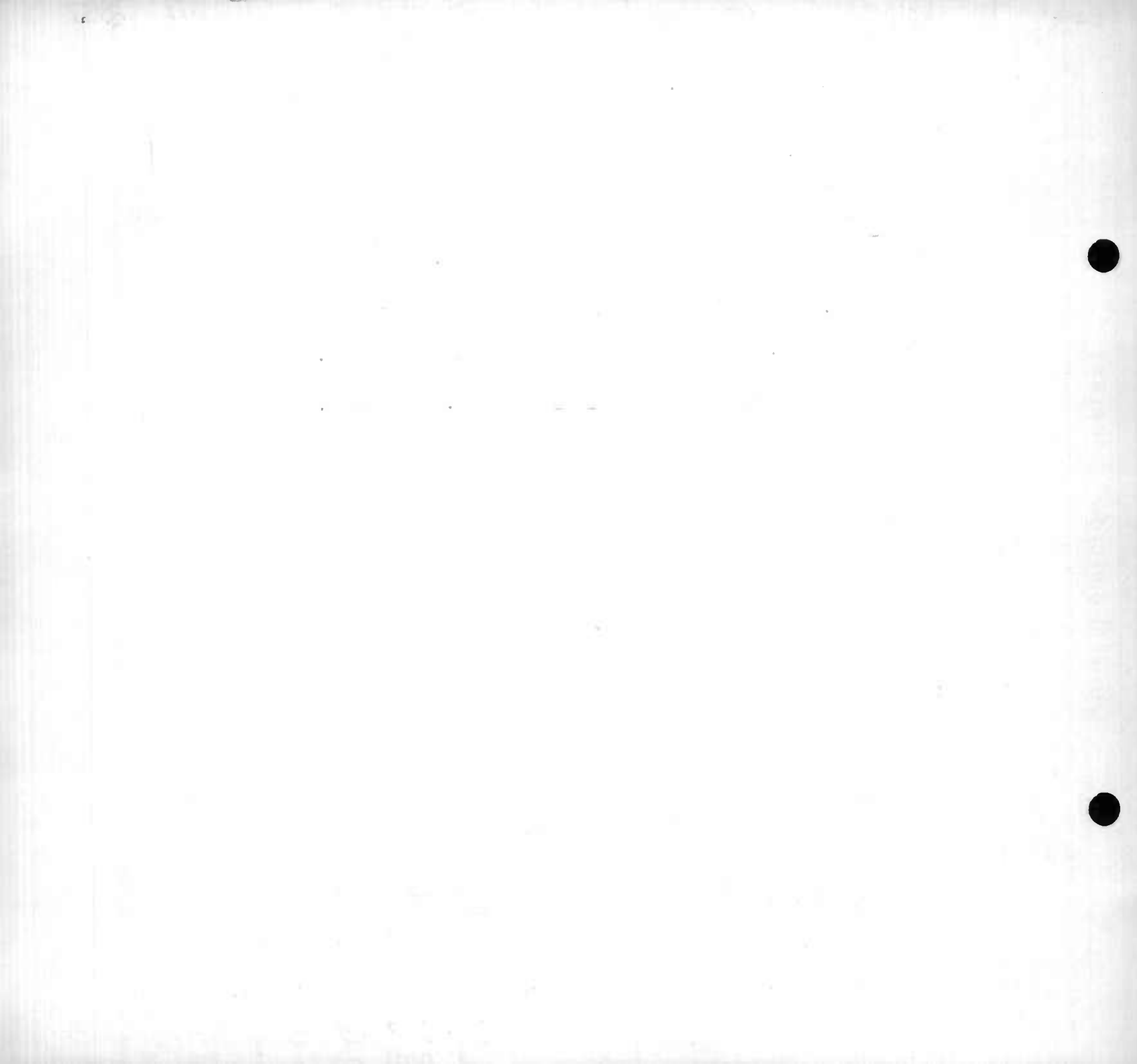
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7866</u>	
BIRTH NO. <u>67 7866</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CONNERY, Miss Clara Elizabeth</u>		2. DATE AND HOUR OF DEATH <u>August 15, 1967</u> <u>8:55</u> a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JENKINS MEMORIAL HOSPITAL</u> <u>1000 S CATON AVE.</u> <u>BALTIMORE, Md 21229</u>		A. STATE <u>Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location) <u>3407 University Place</u> <u>21218</u>		12-02	
5. SEX <u>F</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>10/16/1883</u>	9. AGE (In years lost birthday) <u>83</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edmund Connery</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Dinan</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 32 0741</u>		17. INFORMANT <u>M. Kohler-Medical Record Rm-Jenkins Mem'l</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) <u>Acute myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic heart dis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> <u>1967</u> to <u>8/15</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>8/15</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Raymond Gladue</u> M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>8/15/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>M J. RAYMOND GLADUE</u>		23D. ADDRESS M.D. <u>1000 S Caton Ave. Balto., Md 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/17/1967</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1967</u>		25B. NAME OF REGISTRAR <u>R. B. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-435		67 7868		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7868	
BIRTH NO. <u> </u>				M.E. CASE NO. <u> </u>			
1. NAME OF DECEASED (Type or Print) <u>Anna Goldman</u>				2. DATE AND HOUR OF DEATH <u>August 14, 1967</u> <u>2</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-16</u> D. STREET ADDRESS (If rural, give location) <u>Mt. Sinai Nursing Home</u>			
5. SEX <u>Female</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>About 72</u>	9. AGE (In years lost birthday) <u>72.</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-22-3280</u>		17. INFORMANT <u>David A. Shipley 3113 Parkington Ave Balto.</u>		
18. <u>42211</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Pulmonary embolism</u> DUE TO (B) <u>Arteriosclerotic cardio</u> DUE TO <u>vascular disease</u> (C) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Several years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1966 to Aug 14 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Aug 14 1967</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>Seymour H. Rubin</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8/15/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Seymour H. Rubin</u>				23D. ADDRESS M.D. <u>5415 Park H (Herg) Lts Bldg</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 16, 67</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Hebrew Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Belair Rd. Baltimore, Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 16 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Jack Lewis, Inc.</u>		25D. ADDRESS <u>22100 Rutaw P. Baltimore Md.</u>	

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1
B-650

67 7869 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7869

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROZIEA O. BROWN

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1967

7:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

48

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2201 Maryland Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

April 14, 1896

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

R.R. Conductor

10B. KIND OF BUSINESS OR INDUSTRY

Ral Road

11. BIRTHPLACE (State or foreign country)

Alexandria, Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. I

16. SOCIAL
SECURITY NO.

212-14-2601

17. INFORMANT

ADDRESS

Wm. J. Williams 2850 N. Charles St. Apt. 14B

18. E 900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Multiple traumatic injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

2201 Maryland Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8-11-67 12:40 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down stair well

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Balto., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 16 1967

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7870					67 7870				
BIRTH NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) MARIE F. LEONARD					2. DATE AND HOUR OF DEATH Aug. 15, 1967 7 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1215 N. Calvert St.				
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 27, 1879	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaning woman			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Charleston, S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dolan					14. MOTHER'S MAIDEN NAME Elizabeth Keegan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-56-0291		17. INFORMANT Mrs. Lille LE May 1215 N. Calvert St. Balto.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I MYOCARDIAL INFARCTION DUE TO ANTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE					INTERVAL BETWEEN ONSET AND DEATH SUDDEN				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/14 19 67 to 8/15 19 67 , that (I) (we) last saw the deceased alive on 8/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jos. S. Blum M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 8/16/67	
23C. PHYSICIAN'S NAME (Type) Jos. S. Blum					23D. ADDRESS 1115 N. Calvert St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/67		24C. NAME OF CEMETERY or CREMATORY St. Lawrence Cem.			24D. LOCATION (City, town, or county) (State) Charleston, S.C.		
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967			25B. NAME OF REGISTRAR Robert E. Jackson			25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.			

49-92-81 TN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-520		67 7871		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 7871	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) THOMAS, LOUISE			
2. DATE AND HOUR OF DEATH 14 August 1967 6:55 A.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE VIRGINIA B. COUNTY VIRGINIA			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) NEWPORT NEWS				D. STREET ADDRESS (If rural, give location) 730 36th STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 10-11-91	9. AGE (In years last birthday) 75	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY WILLIAM Scheckells				14. MOTHER'S MAIDEN NAME ANNA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 226-10-2174		17. INFORMANT ADDRESS BCW:RECORDS 4940 EASTERN AVENUE 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I INTRACEREBRAL HEMORRHAGE 2 days				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 11, 1967 to AUGUST 13, 1967 , that (I) was last saw the deceased alive on 13 August 1967 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.							
23A. SIGNATURE Russell D Hicks				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 14 August 1967	
23C. PHYSICIAN'S NAME (Type) DR. RUSSELL D. WICKS				23D. ADDRESS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/67		24C. NAME of CEMETERY or CREMATORY Greenlawn Cemetery		24D. LOCATION (City, town, or county) (State) Newport News, Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St/	

James D. H. H.

12/1/1917

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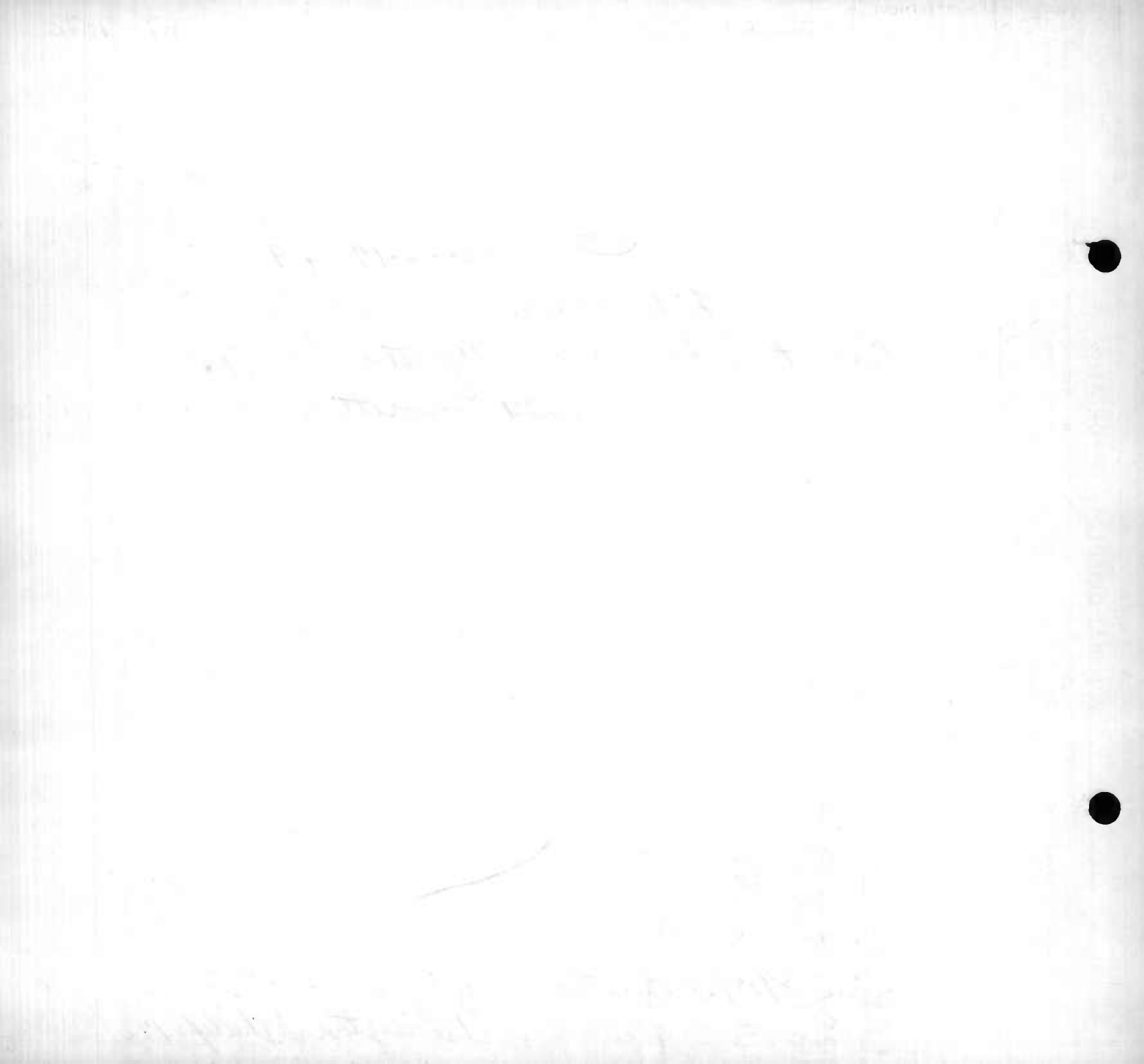
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

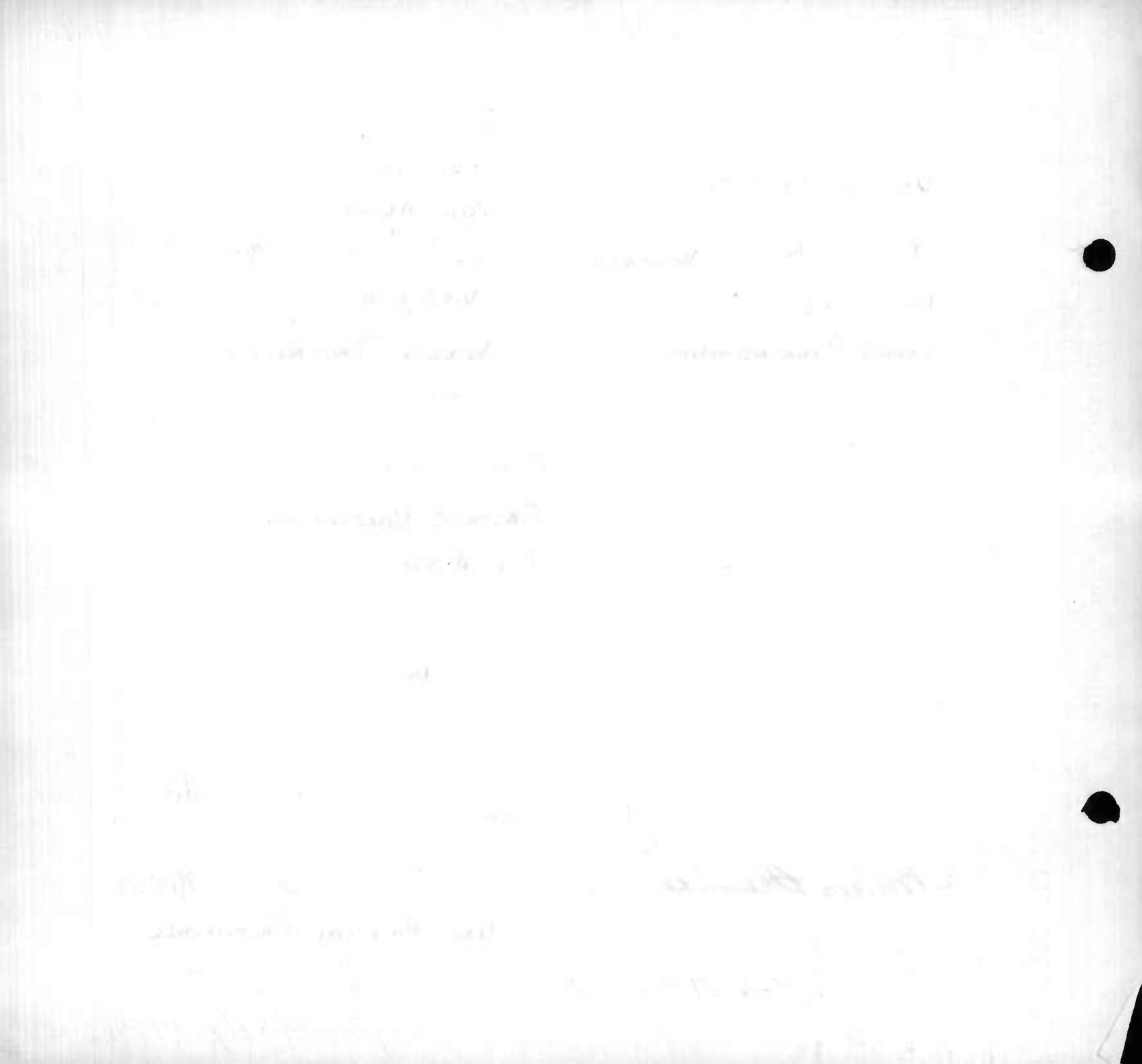
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7872	
BIRTH NO. 67 7872		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDWARDS, WALTER J.		2. DATE AND HOUR OF DEATH 8/14/67 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1826 W NORTH AVE.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-26-17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Fisher Body Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Robert Edwards		14. MOTHER'S MAIDEN NAME Martha Chappel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-2761		17. INFORMANT Emmett Edwards	
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ELECTROLYTE DISTURBANCE DUE TO		19. CAUSE OF DEATH (A) ELECTROLYTE DISTURBANCE (B) PARALITIC ILEUM (C) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days 7 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA & RIGHT HEMIPLEGIA		20. DATE OF OPERATION 2		21. CONDITION FOR WHICH OPERATION WAS PERFORMED CVA & RIGHT HEMIPLEGIA	
22. DATE OF OPERATION 2		23. DATE OF OPERATION 2		24. DATE OF OPERATION 2	
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511. DATE OF OPERATION 2		512. DATE OF OPERATION 2		513. DATE OF OPERATION 2	
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517. DATE OF OPERATION 2		518. DATE OF OPERATION 2		519. DATE OF OPERATION 2	
520. DATE OF OPERATION 2		521. DATE OF OPERATION 2		522. DATE OF OPERATION 2	
523. DATE OF OPERATION 2		524. DATE OF OPERATION 2		525. DATE OF OPERATION 2	
526. DATE OF OPERATION 2		527. DATE OF OPERATION 2		528. DATE OF OPERATION 2	
529. DATE OF OPERATION 2		530. DATE OF OPERATION 2		531. DATE OF OPERATION 2	
532. DATE OF OPERATION 2		533. DATE OF OPERATION 2		534. DATE OF OPERATION 2	
535. DATE OF OPERATION 2		536. DATE OF OPERATION 2		537. DATE OF OPERATION 2	
538. DATE OF OPERATION 2		539. DATE OF OPERATION 2		540. DATE OF OPERATION 2	
541. DATE OF OPERATION 2</					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7873</u>	
BIRTH NO. <u>67 7873</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>NANNIE G. LIPSCOMB</u>		2. DATE AND HOUR OF DEATH <u>8/13/67 - 11:40 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2031 LANVALE</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-20-1889</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>EDWARD CUNNINGHAM</u>			14. MOTHER'S MAIDEN NAME <u>WINNIE DAVENTPORT</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Otis Lipscomb 2021 W. Lanvale</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CHRONIC RENAL DISEASE</u> DUE TO (B) <u>GASTRIC CARCINOMA</u> DUE TO (C) <u>GEN. ASVD.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> 19 <u>67</u> to <u>8/13</u> 19 <u>67</u> , that (I) (we) lost saw the deceased olive on <u>8/13 - 10:45 A.M.</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Maecia Acunide</u>				23B. DATE SIGNED <u>8/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>UNIV. HOSPITAL, BALTIMORE</u>				23D. ADDRESS <u>UNIV. HOSPITAL, BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-16-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cross Road Baptist South Boston VA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Washington Phillips 1727 N. Mount</u>	



1
5-620

67 7874

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7874

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Vernon
ALLEN SHIRK

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1967

5:36 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Carroll

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Taneytown

D. STREET ADDRESS (If rural, give location)

13 Mill Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Never married

8. DATE OF BIRTH

July 2, 1944

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

University

11. BIRTHPLACE (State or foreign country)

Frederick, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Shirk

14. MOTHER'S MAIDEN NAME

Mary Koontz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-42-1350

17. INFORMANT

ADDRESS

Mr/Harry Shirk, Taneytown, Maryland

18. E824.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-10-67

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Head injuries

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Mill Avenue - Taneytown, Md. 56-00

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8-10-67 6:30 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Thrown from motorcycle (Driver)

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/67

23C. NAME of CEMETERY or CREMATORY

Lutheran Cemetery

23D. LOCATION

(City, town, or county)

Taneytown, Carroll, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 16 1967

Robert E. Farkley, M.D.

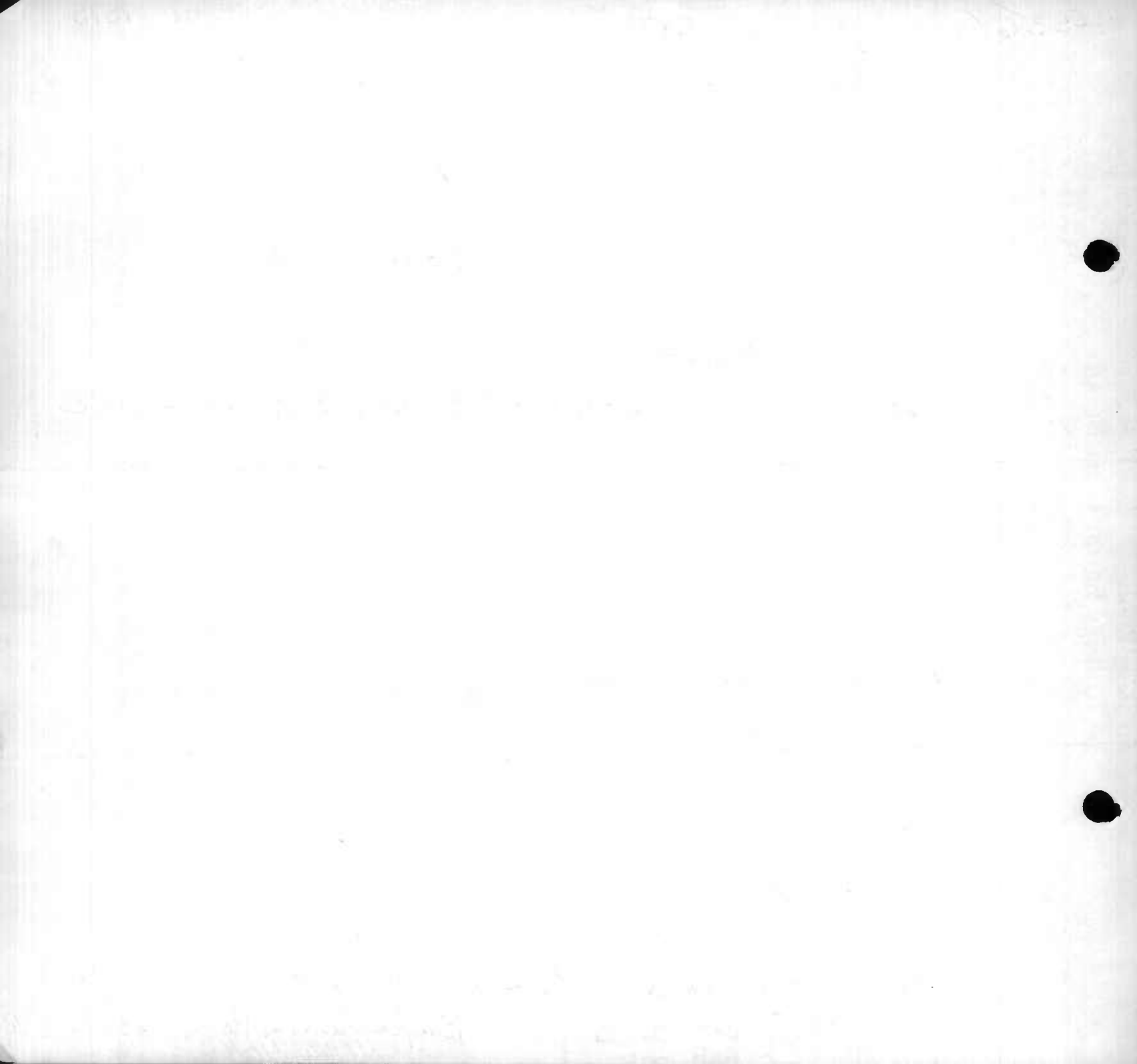
John H. Skiles
C.O. Fuss & Son, Taneytown, Maryland

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7875
BIRTH NO. 67 7875		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HUNTER, LEWIS P.</u>		
2. DATE AND HOUR OF DEATH <u>8/12/67</u> <u>7:50 A</u> M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>AA.C.</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND HOSP</u>		
6. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>PIQUER, BEACH</u>		7. STREET ADDRESS (If rural, give location) <u>8418 PARK RD.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>9/8/11</u>	9. AGE (In years lost birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES, MGR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BOND DISTRIBUTING CO</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THOMAS F Hunter</u>		
14. MOTHER'S MAIDEN NAME <u>ELIZABETH Dell</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, near or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>2182-01-1915</u>		17. INFORMANT <u>Elisabeth J. Hunter - Same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>RUPTURE OF INTRACRANIAL ANEURYSM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8/10/67</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. CAUSE OF DEATH (A) <u>INTERNAL CAROTID</u> (B) <u>INTERNAL CAROTID</u> (C) <u>INTERNAL CAROTID</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>8/10/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MAJOR ANEURYSM</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>8/10/67</u> 19 to <u>8/12/67</u> 19, that (1) (we) last saw the deceased alive on <u>8/12/67</u> 19 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Fred N. Sugar</u>				23B. DATE SIGNED <u>8/12/67</u>
23C. PHYSICIAN'S NAME (Type) <u>FRED N. SUGAR</u>				23D. ADDRESS M.D. <u>UNIVERSITY HOSPITAL</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 15 '67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1967</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>		
ADDRESS <u>3631 Falls Rd</u>		ADDRESS <u>64 North Chesapeake</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">67 7876</p> <p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 24pt; margin: 0;">67 7876</p> <p style="font-size: 18pt; margin: 0;">Registered No.</p>	
<p style="font-size: 24pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>			
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print)</p> <p style="font-size: 18pt; text-align: center;">HARRISON, EDGAR T.</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 18pt; text-align: center;">8-15/67 3:06 P.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 18pt; text-align: center;">Saint Agnes Hospital Caton & Wilkens Aves. 2129</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)</p> <p>A. STATE B. COUNTY</p> <p style="font-size: 18pt; text-align: center;">Maryland Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p style="font-size: 18pt; text-align: center;">Baltimore</p> <p>D. STREET ADDRESS (If rural, give location)</p> <p style="font-size: 18pt; text-align: center;">3235 Rosalie Rd. v XXXX 21227</p>	
<p>5. SEX</p> <p style="font-size: 18pt; text-align: center;">Male</p>	<p>6. RACE</p> <p style="font-size: 18pt; text-align: center;">white</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> <p style="font-size: 18pt; text-align: center;">Married</p>	<p>8. DATE OF BIRTH</p> <p style="font-size: 18pt; text-align: center;">10/18-1911</p>
<p>9. AGE (In years last birthday)</p> <p style="font-size: 18pt; text-align: center;">55</p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt; text-align: center;">Rigger</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="font-size: 18pt; text-align: center;">Md. Drydock</p>	<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 18pt; text-align: center;">Virginia</p>
<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 18pt; text-align: center;">U.S.A.</p>		<p>13. FATHER'S NAME</p> <p style="font-size: 18pt; text-align: center;">Thos. Harrison</p>	
<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 18pt; text-align: center;">Elizabeth Young</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 18pt; text-align: center;">No</p>	
<p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 18pt; text-align: center;">224-14-8589</p>		<p>17. INFORMANT ADDRESS</p> <p style="font-size: 18pt; text-align: center;">Mrs. Sara M. Harrison, 3235 Rosalie Rd. 21227</p>	
<p>18. CAUSE OF DEATH</p> <p style="font-size: 18pt; text-align: center;">491X4322.1</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p style="font-size: 18pt; text-align: center;">(A) Broncho- Pneumonia</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p style="font-size: 18pt; text-align: center;">(B) Chronic Pulmonary Disease</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="font-size: 18pt; text-align: center;">(C) (Non- Tuberculous) TBM</p> <p style="font-size: 18pt; text-align: center;">3 Lung Cyst left</p> <p style="font-size: 18pt; text-align: center;">4 Status post thoracotomy left old</p> <p style="font-size: 18pt; text-align: center;">5 History Alcoholism Chronic</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p style="font-size: 18pt; text-align: center;">1 week</p> <p style="font-size: 18pt; text-align: center;">Three Years</p> <p style="font-size: 18pt; text-align: center;">Three Years</p> <p style="font-size: 18pt; text-align: center;">Three Years</p> <p style="font-size: 18pt; text-align: center;">Unknown</p>			
<p>19A. DATE OF OPERATION</p> <p style="font-size: 18pt; text-align: center;">0</p>			
<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p style="font-size: 18pt; text-align: center;">II</p>			
<p>20A. AUTOPSY? (Yes or No)</p> <p style="font-size: 18pt; text-align: center;">No</p>			
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p style="font-size: 18pt; text-align: center;">21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Approx.)</p> <p style="font-size: 18pt; text-align: center;">(Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 8/15/67 19 to 8/15/67 19, that (I) (we) last saw the deceased alive on 8/15/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="font-size: 18pt; text-align: center;">W. E. McGrath M.D.</p>		<p>23B. DATE SIGNED</p> <p style="font-size: 18pt; text-align: center;">8/15/67</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 18pt; text-align: center;">W. E. McGrath M.D.</p>		<p>23D. ADDRESS</p> <p style="font-size: 18pt; text-align: center;">St. Agnes Hosp Balto ag mc</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 18pt; text-align: center;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 18pt; text-align: center;">8-18-67</p>	
<p>24C. NAME of CEMETERY or CREMATORY</p> <p style="font-size: 18pt; text-align: center;">Meadowridge Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 18pt; text-align: center;">Howard County, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 18pt; text-align: center;">AUG 17 1967</p>		<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 18pt; text-align: center;">Robert E. Taylor, Jr.</p>	
<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 18pt; text-align: center;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</p>		<p>25D. ADDRESS</p>	

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67 7877 BALTIMORE CITY HEALTH DEPARTMENT

67 7877

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD G. DISNEY, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1967 8:23 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

503 Parksley St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

503 Parksley Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1898

9. AGE (In years last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Mail Carrier

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward A. Disney

14. MOTHER'S MAIDEN NAME

Mollie Cunningham

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-44-3403

17. INFORMANT

ADDRESS

21223

Mrs. Margaret A. Disney, 503 Parksley Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Arteriosclerosis Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Aut. Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 16, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

8-19-67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 17 1967

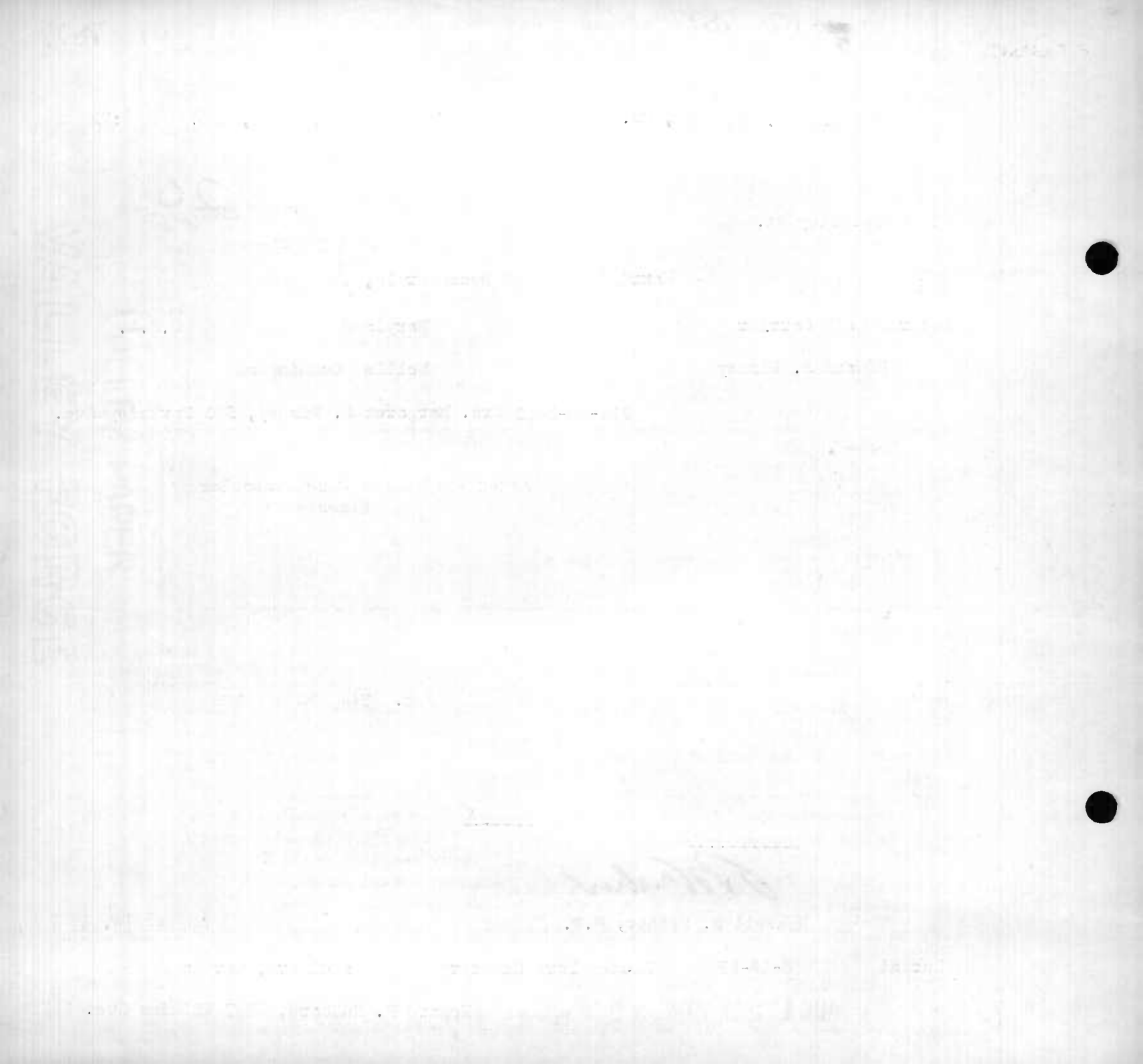
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

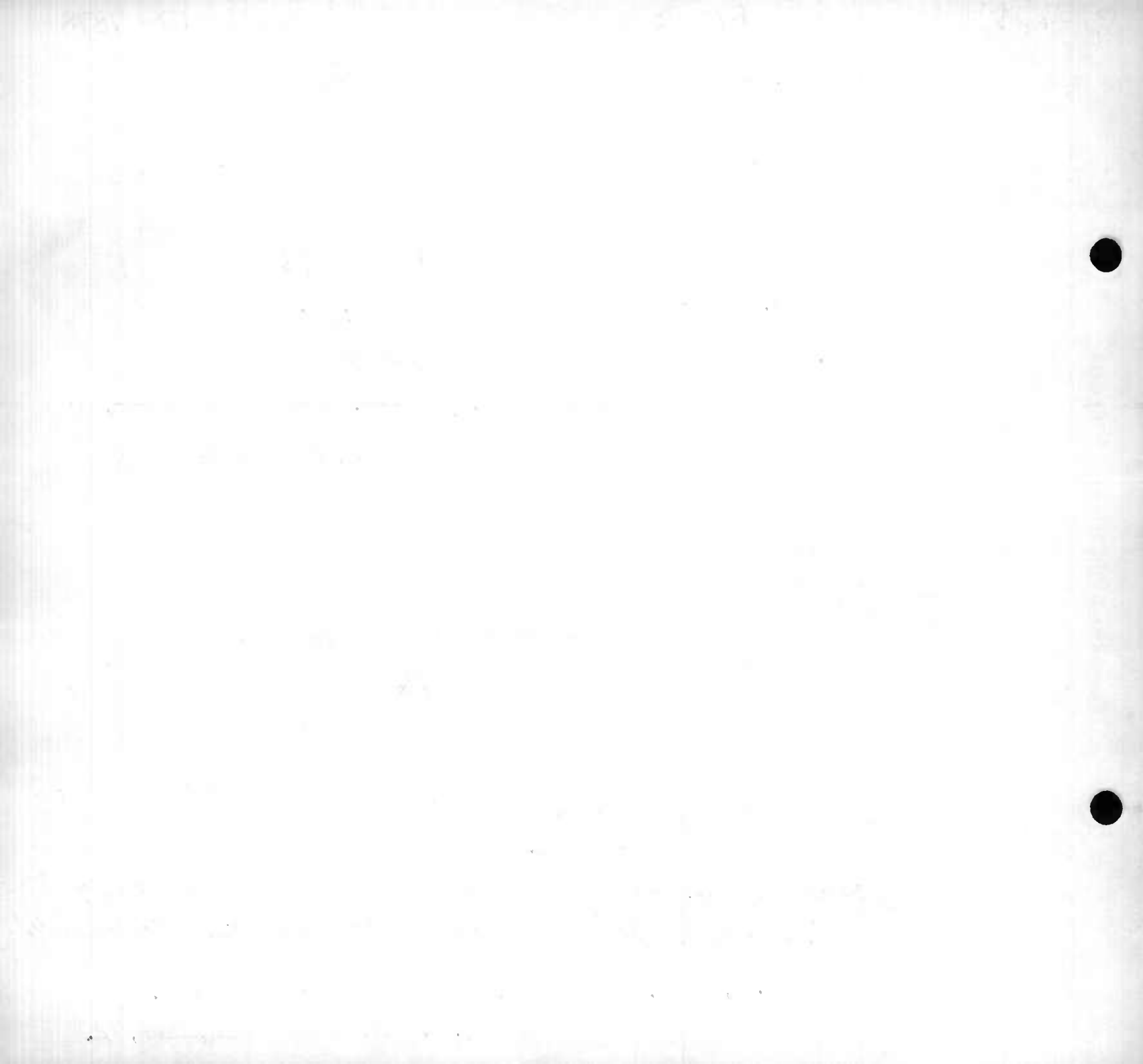
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY AND HEALTH DEPARTMENT		Registered No.	
67 7878		CERTIFICATE OF DEATH		67 7878	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Melvin Burnham		11-30 PM 8/14/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
42 Sinai hospital		MD Balt. Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore Pikesville 53-00			
		D. STREET ADDRESS (If rural, give location)			
		McDonough Rd			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	Married	3/18/91	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Owner of Melvin J. Burnham Company		Baltimore CO. Md.		USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William E. Burnham			Wilhelmina Dibb		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-16-5478		Mr. Charles M. Burnham Reisterstown, Md	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		A) DUE TO		2 hrs.	
ANTECEDENT CAUSES		B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Previous myocardial infarction			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 8/14 1967 to 8/14 1967, that (I) (we) last saw the deceased alive on 8/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Louis H. Schaffer				8/14/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Louis H. Schaffer		M.D. 722 W Cold Spring Lane, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Aug. 18, 67	St. Thomas Cemetery	Owings Mills, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
AUG 17 1967	R. L. E. Taylor	J. F. Eline & Sons Reisterstown, Md.			



FUNERAL DIRECTOR: IMPORTANT

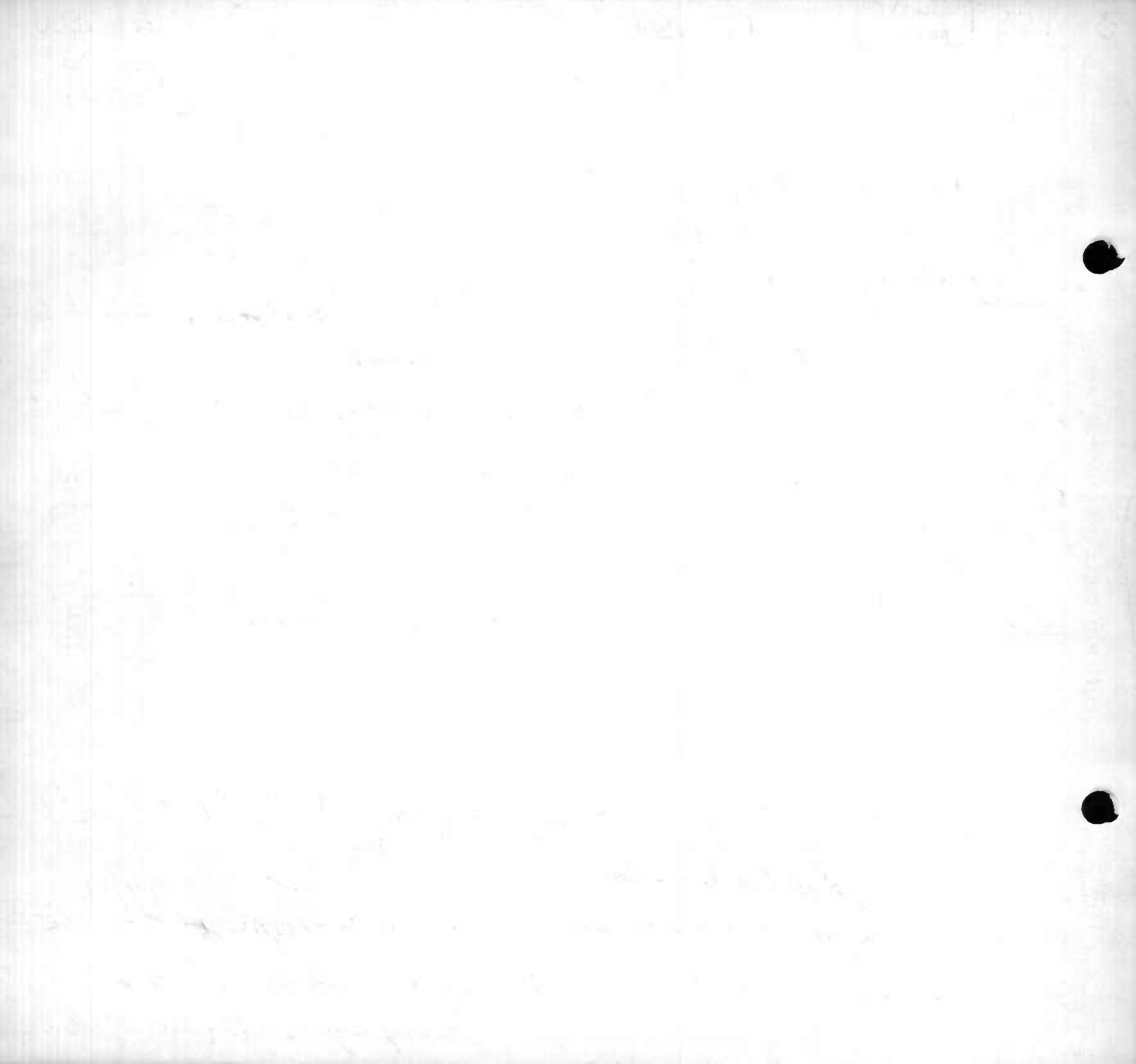
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7879</u>	
BIRTH NO. <u>67 7879</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SARAH MYEROVITZ</u>		2. DATE AND HOUR OF DEATH <u>AUGUST 14, 1967</u> <u>1 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4918 QUEENS BERRY AVE</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u>	
				D. STREET ADDRESS (If rural, give location) <u>4918 QUEENS BERRY AVE</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	B. DATE OF BIRTH <u>3/15/1891</u>	9. AGE (In years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SIDNEY</u>			14. MOTHER'S MAIDEN NAME <u>FANNIE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>MRS IRVING BASS</u>		ADDRESS <u>SAME</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Heart Failure</u>		CAUSE OF DEATH (A) DUE TO <u>Arteriosclerotic Hypertensive C.V. disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Uncomplicated Hypertension + fibrillation</u>		(B) DUE TO <u>Arteriosclerotic Hypertensive C.V. disease</u>		<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Operated on C.V. 7 months with peripheral neuropathy</u>		(C) DUE TO <u>Uncomplicated Hypertension + fibrillation</u>		<u>9 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>1967</u> that (I) (we) lost saw the deceased alive on <u>August 13, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (d/d) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph R. Myerowitz</u>				23B. DATE SIGNED <u>8-15-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph R. Myerowitz</u>				23D. ADDRESS <u>6615 Reisterstown Rd Towson Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/15/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Progressive Sick Relief</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis</u>	
				ADDRESS <u>Garrison</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7880 CERTIFICATE OF DEATH					Registered No. 67 7880				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) BEARMAN, OLIVE A.					2. DATE AND HOUR OF DEATH 8/14/67 2-20PM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hosp. of Balto					A. STATE Md B. COUNTY Balto Co.				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Randallstown 53-00				
D. STREET ADDRESS (If rural, give location) 3803 Doredale Court									
5. SEX F	6. RACE W	7. NEVER MARRIED WIDOWED DIVORCED (specify)		8. DATE OF BIRTH July 26, 1905	9. AGE (In years lost birthday) 62 yrs	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Suffolk, England		12. CITIZEN OF WHAT COUNTRY? British Subject			
13. FATHER'S NAME Herbert Filby				14. MOTHER'S MAIDEN NAME unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. 220-38-7156		17. INFORMANT Aun Maggitti 3803 Doredale Court			
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis — wide spread secondary deposits ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 8 months					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malignant Cachexia					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/8/1967 to 8/14/1967 , that (I) (we) lost saw the deceased olive on 8/14/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Balasubramanian M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) R. BALASUBRAMANIAN M.D.					23D. ADDRESS SINAI HOSPITAL, BALTIMORE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-67		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) Balto Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Loring Myers 8728 Liberty Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		67 7881		BALTIMORE CITY HEALTH DEPARTMENT		67 7881	
1. NAME OF DECEASED (Type or Print) ADAL BURGAMY				2. DATE AND HOUR OF DEATH 8/13/67 9:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-01 D. STREET ADDRESS (If rural, give location) 5115 EUGENE AVE. #21206			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH AUG. 6, 1891	9. AGE (In years, lost birthday) 76	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN M. QUINN				14. MOTHER'S MAIDEN NAME ROSE FUNK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-9397A		17. INFORMANT WILLIAM A. BURGAMY		ADDRESS 118 S. CONKLING ST. BALTO. 21224, MD.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD				INTERVAL BETWEEN ONSET AND DEATH 8 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 8/5/67 19 to 8/13 19 67 , that (I) last saw the deceased alive on 8/13/67 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.							
23A. SIGNATURE Abe Levy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/13/67	
23C. PHYSICIAN'S NAME (Type) Abe Levy		23D. ADDRESS M.D. Sinai Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-16-67		24C. NAME of CEMETERY or CREMATORY OAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. BA, CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Charles H. Geiler		ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.	

31st Hospital of the Line

W. M. W.

1st Lt. J. H. W.

8/1/23

8/2/23

8/3/23

✓
1st Lt. J. H. W.

✓
1st Lt. J. H. W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7882		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7882	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) SUTTON, ETHEL S.		2. DATE AND HOUR OF DEATH AUGUST 14, 1967 11:35A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital 601 N. Broadway Baltimore 5, Md.		A. STATE B. COUNTY 204 Maryland Ave., Ridgely, MD.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CAROLINE Co 55-00			
		D. STREET ADDRESS (If rural, give location)			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-23-09	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME WILLIAM SHIRLEY		14. MOTHER'S MAIDEN NAME MABEL GROVES		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Harold Ebling, Ridgely, Md.	
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) - Sub-arachnoid Hemorrhage due to ruptured aneurysm of the Middle Cerebral Artery.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH About 12 days.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None.					
19A. DATE OF OPERATION 8/11/67 & 8/13/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Sub-arachnoid hemorrhage.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/8/67 to 8/14/67, that (I) (we) last saw the deceased alive on 8/14/67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE C. Bhushan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) CHHARI BHUSHAN		23D. ADDRESS The Johns Hopkins Hospital Baltimore 5, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 17 1967		24C. NAME OF CEMETERY or CREMATORY Denton	
				24D. LOCATION (City, town, or county) (State) Denton, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Jy Virgil Moore, Denton, Md.	

11-11-11

The following is a list of the names of the persons who have been named in the following cases:

11-11-11

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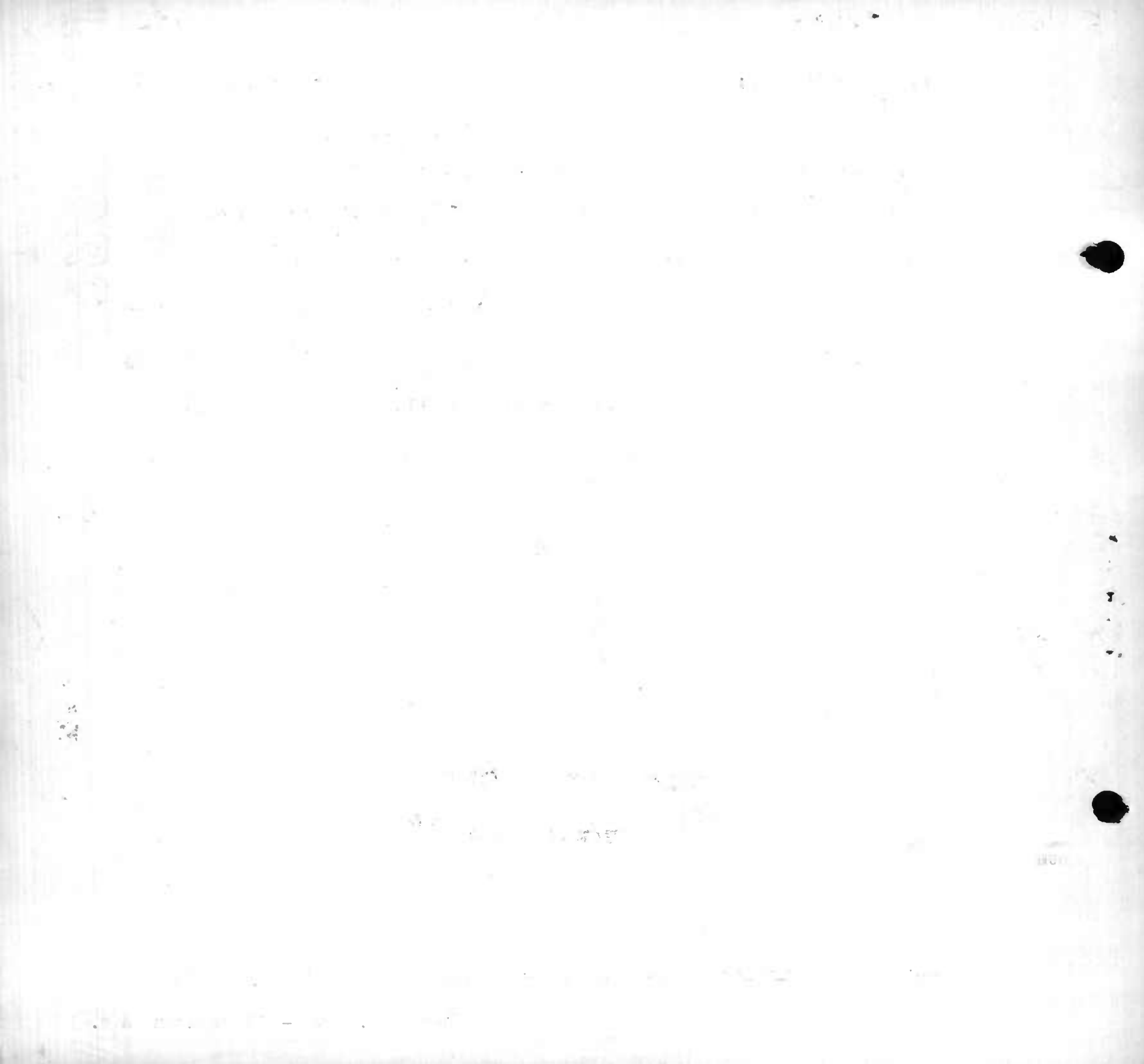
11-11-11

11-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 7883		CERTIFICATE OF DEATH		Registered No. 9537 7883		
1. NAME OF DECEASED (Type or Print) Mary Garrett				2. DATE AND HOUR OF DEATH August 14, 1967 1:30 P.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) COMMUNITY NURSING HOMES, INC. Bolton Hill 1400 John St				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-06 D. STREET ADDRESS (If rural, give location) 2801 Raynor Ave						
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/26/12	9. AGE (In years last birthday) 95	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Lucy Smart unknown						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 214-58-8443		17. INFORMANT Patients chart				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Infected bedsores near				CAUSE OF DEATH A. Fracture right hip B. antennular generalized C. Chronic brain syndrome				INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks		
19A. DATE OF OPERATION 7/67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture right hip		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bolton Hill Nursing Home				
21D. TIME OF INJURY (Approx.) 6-15-67				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? apparently fell from wheel chair				
22. I certify that (I) (this hospital) attended the deceased from 7/28 1967 to 8/14 1967 , that (I) (we) last saw the deceased alive on 8/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE ALLAN H. MACHT						M.D. <input checked="" type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/67		
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT						23D. ADDRESS 2 E READ ST Baltimore, Md 21202				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-67		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967			25B. NAME OF REGISTRAR R. B. E. Taylor			25C. FUNERAL DIRECTOR Charles R. Law - 802 Madison Ave.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7884	
BIRTH NO. 67 7884		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HENRY J. SCHAEFER		2. DATE AND HOUR OF DEATH 8/15/67 7:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE; MD 21231		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2329 MILLMAN Street.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/19/1910	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SINCLAIR OIL CO.		10B. KIND OF BUSINESS OR INDUSTRY CLERK		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HENRY SCHAEFER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. Katherine A. Schaefer - 2329 Millman St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 153.8 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) TOXEMIC SHOCK		CAUSE OF DEATH (A) DUE TO CA. OF Colon (B) DUE TO 9 PERITONITIS (C)		INTERVAL BETWEEN ONSET AND DEATH Few hours Few days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/12/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. COLON		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 8/11/1967 to 8/15/1967 , that (1) (we) last saw the deceased alive on 8/15/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Krishna Reddy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) KRISHNA REDDY		23D. ADDRESS CHURCH HOME & HOSPITAL; BALTO: 31			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-19-67		24C. NAME OF CEMETERY or CREMATORY TRUID RIDGE Cem.	
24D. LOCATION (City, town, or county) (State) BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Arthur Miller - 2334 Jefferson St.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7885		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7885	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE FREDERICK SPONHEIMER		2. DATE AND HOUR OF DEATH 8-15-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 137 N. MONTFORD AVE.		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 6-0-2 D. STREET ADDRESS (If rural, give location) 137 N. MONTFORD AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-1-1908	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LETTERMAN		10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE SPONHEIMER		14. MOTHER'S MAIDEN NAME SOPHIA KOERBER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clara R. Sponheimer - 137 N. Montford Ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROTIC HEART DISEASE		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12 1967 to August 15 1967 , that (I) (we) last saw the deceased alive on August 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew Lemischka		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED August 16-67	
23C. PHYSICIAN'S NAME (Type) ANDREW LEMISCHKA		23D. ADDRESS 2608 E. BALTIMORE ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-18-67		24C. NAME of CEMETERY or CREMATORY MORELAND MEMORIAL Cem.	
24D. LOCATION BALTO., MD.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Harold Miller - 2334 Jefferson St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ODELL REASE

2. DATE AND HOUR PRONOUNCED DEAD

August 15, 1967 4:57 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1715 Barclay Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1715 Barclay Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9/28/35

9. AGE (in years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Queenie Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

238-56-8117

17. INFORMANT

ADDRESS

Mrs Queenie Bell, 1606 N Calvert St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/19/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION (City, town, or county) (State)

Adolphus Halstead 1206 W North Ave
A.A. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

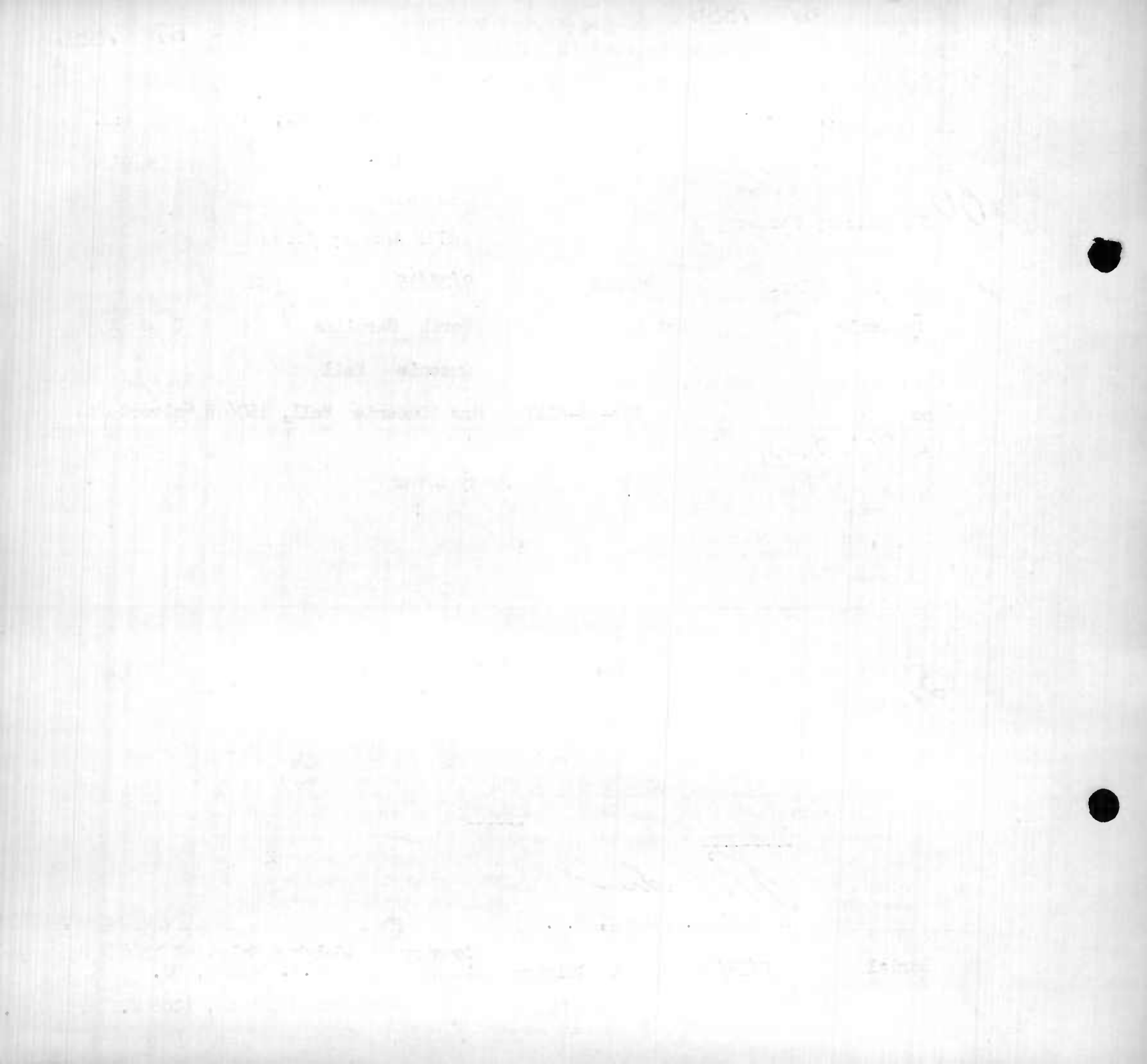
AUG 17 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

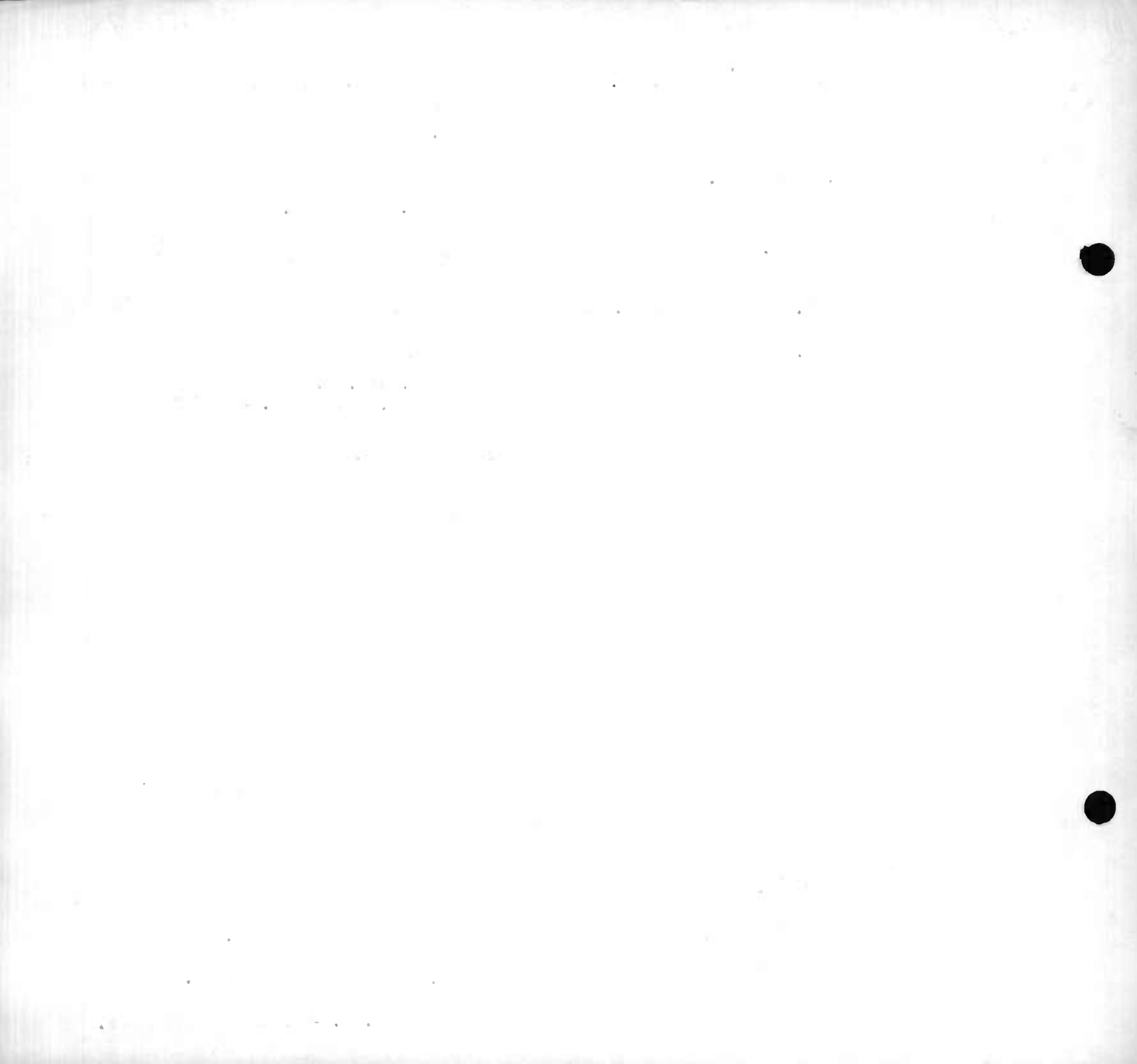
Adolphus Halstead, 1206 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO.	
545		67 7887		67 7887	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		George Bahnline, Sr.		Aug. 15, 1967 2:50 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
300 N. Athol Ave.			Md. Baltimore		
5. SEX M			6. RACE Cauc.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH 3/13/99			9. AGE (In years lost birthday) 68		10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Dept.			10B. KIND OF BUSINESS OR INDUSTRY Bal to. City		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George F. Bahnline			14. MOTHER'S MAIDEN NAME Mary Hamil		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Geo. F. Bahnline ADDRESS 300 N. Athol Ave. - 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) DUE TO CEREBRAL VASCULAR H.S.V.D.		INTERVAL BETWEEN ONSET AND DEATH 30'
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO DIABETES MELLITUS		10 yrs 15-20 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1952 19 to July 8/15/67 19 that (I) (we) last saw the deceased alive on 8/15/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert Lapp				23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) Herbert Lapp				23D. ADDRESS 4804 Frederick Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/67		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 17 1967		24F. NAME OF REGISTRAR Robert E. Fisher	
24G. DATE REC'D BY HEALTH DEPT. AUG 17 1967		24H. NAME OF REGISTRAR Robert E. Fisher		24I. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 7888					CERTIFICATE OF DEATH					Registered No. 67 7888				
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Russell Gilliam					2. DATE AND HOUR OF DEATH 8 12 67 1 30 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 802 N. CAROLINE ST. 21205									
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-6-14		9. AGE (In years lost birth-day) 53		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDMOND					14. MOTHER'S MAIDEN NAME JULIA GRAVES									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES					16. SOCIAL SECURITY NO.					17. INFORMANT RECORDS: BCM 4940 EASTERN AVE. BALTO. 21224,				
18. 141.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION, last. Metastatic carcinoma of lung Anaplastic sq cell carcinoma of tongue					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 DAY 6 months 6+ months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. No														
19A. DATE OF OPERATION 6-28-67					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploration of lymphatic					20A. AUTOPSY? (Yes or No) YES				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/1/1967 to 8/12/1967 that (I) (we) last saw the deceased alive on 8/12/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Paul Kruger					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 8/12/1967				
23C. PHYSICIAN'S NAME (Type) DR. PAUL KRUGER					23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/12/67					24C. NAME OF CEMETERY or CREMATORY Balto. National				
24D. LOCATION (City, town, or county) (State) 5501 Frederick St														
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967					25B. NAME OF REGISTRAR Robert E. Taylor, MA					25C. FUNERAL DIRECTOR Joseph L. Rock, Jr.				
					ADDRESS 1304 N. Central St									

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W-650

67 7889

BALTIMORE CITY HEALTH DEPARTMENT

67 7889

BIRTH NO. 6520416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CONSTANTIN WARREN		2. DATE AND HOUR PRONOUNCED DEAD August 16, 1967 8:20 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1827 N. Port Street	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 8-19-65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 yr. 11
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Warren		14. MOTHER'S MAIDEN NAME Mable Deveaux	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS David Warren 1827 Port Street
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E919.0 I Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bedroom	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1827 N. Port St. 2nd floor
21D. TIME OF INJURY (APPROX.) 8 13 67 5:30 p.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Subject shot accidentally by sister
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 16, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 8-19-67	23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	23D. LOCATION (City, town, or county) (State) Baltimore, Maryland
24A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.	24C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.

W 856.4

WATKINS FORGE

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		67 7890	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print) WILLIE MARSHAL			2. DATE AND HOUR PRONOUNCED DEAD August 15, 1967 6:05 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital D.O.A.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1920 McCulloh Street		
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married - Sep.	8. DATE OF BIRTH 7-26-10	9. AGE (in years last birthday) 57	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 250186326		17. INFORMANT ADDRESS Ella M. Amos 5 1920 McCulloh St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fractured left leg					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown	
21D. TIME OF INJURY (APPROX.) Unknown		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Unknown	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify) Burial			23B. DATE 8-15-67		23C. NAME OF CEMETERY or CREMATORY Arbutus Men. Pk.
23D. LOCATION (City, town, or county) (State) Arbutus, Maryland.			24A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		
24B. NAME OF REGISTRAR Robert E. Taylor			24C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home. 1348 Calhoun St.		

Replaced 9/13/67 See Letter In File.

J.P.B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7891		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7891	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GARLAND P. COGLE (COGLE)		2. DATE AND HOUR OF DEATH 8/14/67 4:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Gen. Hosp.		A. STATE B. COUNTY Md. Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218			
		D. STREET ADDRESS (If rural, give location) 905 McKenrin Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/1/83	9. AGE (In years last birthday) 84 (8)	II Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer-Railroad		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jonathan Cogle		14. MOTHER'S MAIDEN NAME Lucy Deery	
15. Was Deceased Ever in U. S. Armed Forces (yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717-078723		17. INFORMANT Mrs. Mildred Weiss	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Bronchitis & Pulmonary Edema		CAUSE OF DEATH (A) Arteriosclerosis & hypertensive disease (B) Coronary artery disease (C) Carcinoma of bladder Pulmonary Emphysema, severe		INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/26 19 67 to 8/14 19 67, that (I) (we) last saw the deceased alive on 8/14 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) Md. General Hospital		23D. ADDRESS Md. General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/67		24C. NAME of CEMETERY or CREMATORY Fairview Lutheran Cemetery	
				24D. LOCATION (City, town, or county) (State) Bolivar, West Virginia.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR R. E. Fulkerson		25C. FUNERAL DIRECTOR L. J. Beck, Inc.	
				ADDRESS Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		67 7892		CERTIFICATE OF DEATH		Registered No. 67 7892	
1. NAME OF DECEASED (Type or Print) EDWARD BAUERNSCHMIDT				2. DATE AND HOUR OF DEATH 8-15-67 6:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21213 D. STREET ADDRESS (If rural, give location) 2209 MAYFIELD AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-17-86	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD M. BAUERNSCHMIDT				14. MOTHER'S MAIDEN NAME ANNIE KRESS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 210-32-3817		17. INFORMANT ADDRESS Frederick J. Singley Atty. 1st Nat. Bank Bldg			
18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebrovascular accident DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 8/15/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3:30 PM 8/15 19 67 to 6:15 PM 8/15 19 67 , that (I) (we) last saw the deceased alive on 6:15 8/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roy S. Weiner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) Roy S. Weiner				23D. ADDRESS The Johns Hopkins			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/67		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Leonard J. Ruek Inc.		ADDRESS 5305 Harford Rd. 21211	

The Johns Hopkins

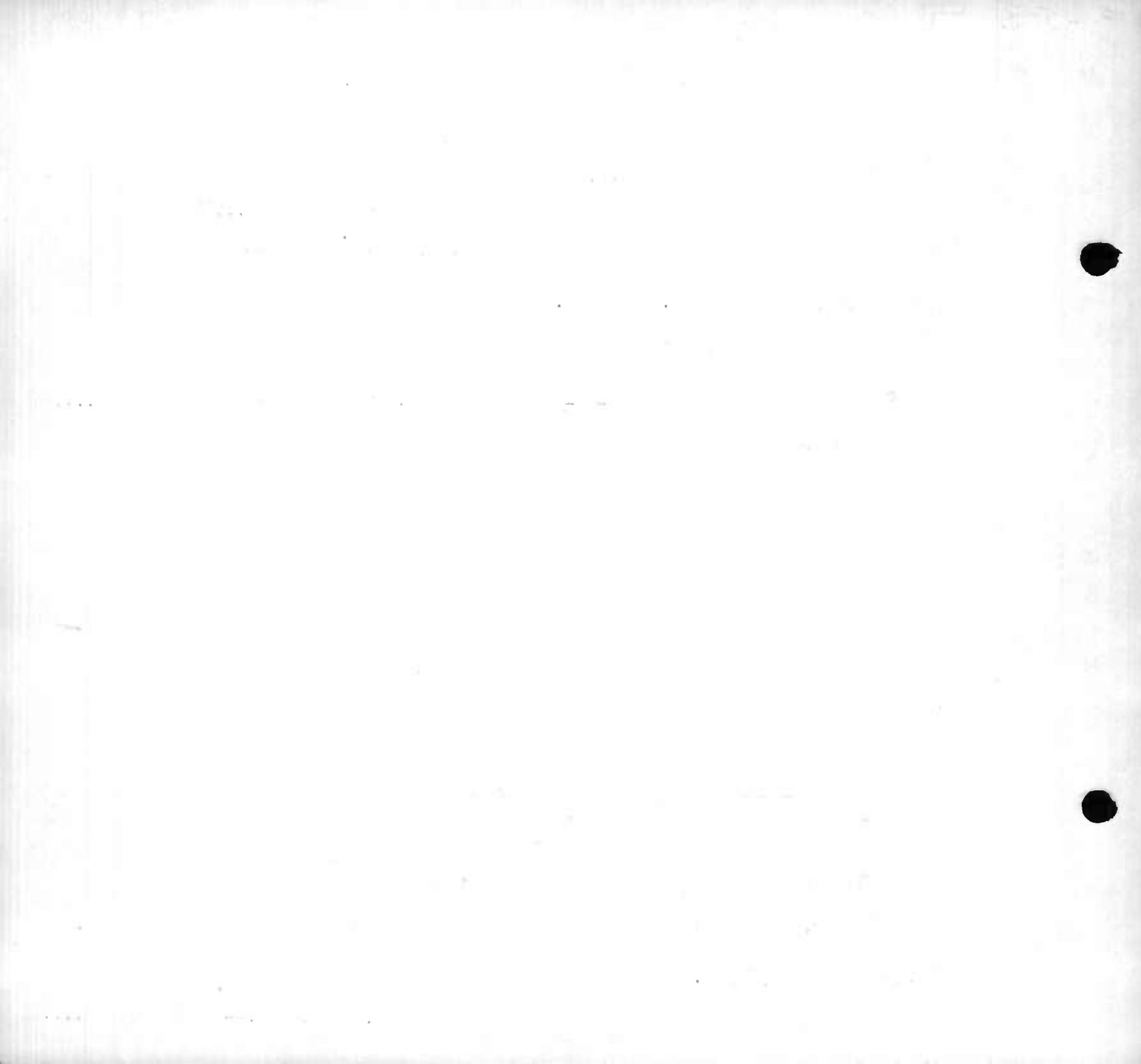
187

no

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7893	
BIRTH NO. 67 7893		67 7893		CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) ALFRED HENRY SANTONI		
2. DATE AND HOUR OF DEATH Aug. 16, 1967			2 30 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00			A. STATE Maryland		
(If not in hospital or institution, give street address or location) 1911 Ramblewood Road...14			B. COUNTY Baltimore		
5. SEX male			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
6. RACE white			D. STREET ADDRESS (If rural, give location) 1911 Ramblewood Road, ...14		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married			E. AGE (In years lost birthday) 62 63		
8. DATE OF BIRTH Dec. 1, 1904			F. Under 1 Yr. Months Days Hours Min. 27-38		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Roller			10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		
11. BIRTHPLACE (State or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Antonio Santoni			14. MOTHER'S MAIDEN NAME Giacinta Virgil		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-10-5023		
17. INFORMANT Peter E. Santoni			ADDRESS 1911 Ramblewood Rd....14		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420-1 I			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) Coronary Artery Occlusion		
ANTECEDENT CAUSES			(B) Arterio Sclerosis Vascular		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Diabetes		
II			INTERVAL BETWEEN ONSET AND DEATH 4 hours		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Unknown		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from October 29, 1958 to August 16, 1967 , that (I) was lost saw the deceased alive on 8/14 1967 and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE Phillbert Artigiani			23B. DATE/SIGNED 8/16/67		
23C. PHYSICIAN'S NAME (Type) Dr. Phillbert Artigiani			23D. ADDRESS 2305 Mayfield Avenue, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/19/67.		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967			
25B. NAME OF REGISTRAR Leonard J. Ruck		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md....14			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7894	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 7894 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Hubert Ames (Herbert)			2. DATE AND HOUR OF DEATH August 15, 1967 8:25 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital Inc. 1514 Division Street Baltimore, Maryland #21217			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1609 Cliftview Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 8/2/11	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia, Northampton	
13. FATHER'S NAME WILLIE J. AMES			14. MOTHER'S MAIDEN NAME AGNES AMES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-4790		17. INFORMANT ADDRESS Julia Ames (wife) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 15, 1967 to August 15, 1967 , that (I) (we) last saw the deceased alive on August 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
23A. SIGNATURE <i>Carado</i>			23B. DATE SIGNED 8/16/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-67		24C. NAME of CEMETERY or CREMATORY Balto. National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		25B. NAME OF REGISTRAR MORTON & DYETT F.H.		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens	

22

Central University

Parade

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7895

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

E.

LUCY BURSE

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1967 3:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

210 W. Read Street

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Female

Colored

WIDOWED

July 22, 1906 61

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Middlesex Co., Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHNSON T. ACKES

14. MOTHER'S MAIDEN NAME

SARAH BURNETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. George Burse, Jr. 2323 N. Longwood

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of uterus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREM.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

August 16, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-21-67

23C. NAME of CEMETERY or CREMATORY

Mount Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

A.A. Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

WILLIAM POLLOCK

Special Agent

THE NEW YORK OFFICE

RECEIVED

May 15, 1900

MEMORANDUM

TO THE DIRECTOR

FROM THE NEW YORK OFFICE

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
W-252 67 7896		CERTIFICATE OF DEATH		67 7896	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		WASHINGTON, ROBERT E.		15 AUGUST 1967 — 10:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
(If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals			Maryland Baltimore		
4940 Eastern Avenue			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
Baltimore, Maryland 21224			53-00		
5. SEX			D. STREET ADDRESS (If rural, give location)		
Male			649 South Avondale Road 21222		
6. RACE			8. DATE OF BIRTH		
Negro			7-4-1904		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			9. AGE (In years lost birthday)		
Married			63		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Laborer			Virginia, Balty		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY		
Sparrows Point			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNK.			Sarah Washington		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			213-09-1092		
17. INFORMANT			ADDRESS		
Records: BCH-4940 Eastern Avenue			21224		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ADENOCARCINOMA of RECTUM WITH WIDESPREAD METASTASES					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 7/28/1967 to 8/15/1967, that (I) last saw the deceased alive on 15 AUGUST 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Russell D Hicks				15 AUGUST 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Russell D. Hicks				4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-19-67		St. John Bapt. Ch. Cem. Balty	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Virginia		AUG 17 1967		MORTON E. Dyer F.H.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				1701 Laurens	

Association of Record
with various members

1917

James O. Hill

12 August

67

12 August 1917

1
S-300

67 7897

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No 67 7897

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) CECELIA SCOTT		2. DATE AND HOUR PRONOUNCED DEAD August 15, 1967 6:50 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2430 Druid Hill Ave.	
FULL NAME OF HOSPITAL OR INSTITUTION 2430 Druid Hill D.O.A.			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH October 10, 1927 39
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 39
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WINSTON H. JONES		14. MOTHER'S MAIDEN NAME EVELYN EATON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Michael Scott
		ADDRESS 2430 Druid Hill	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Epilepsy DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 8-17-67	
23C. NAME of CEMETERY or CREMATORY BALTO. NAT'L CEM.		23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
24A. DATE REC'D BY HEALTH DEPT. AUG 17 1967		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens St.		ADDRESS	

19670007907

October 11, 1947 32

RECEIVED, 10/11/47

U. S. DEPARTMENT OF JUSTICE

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

U. S. DISTRICT COURT

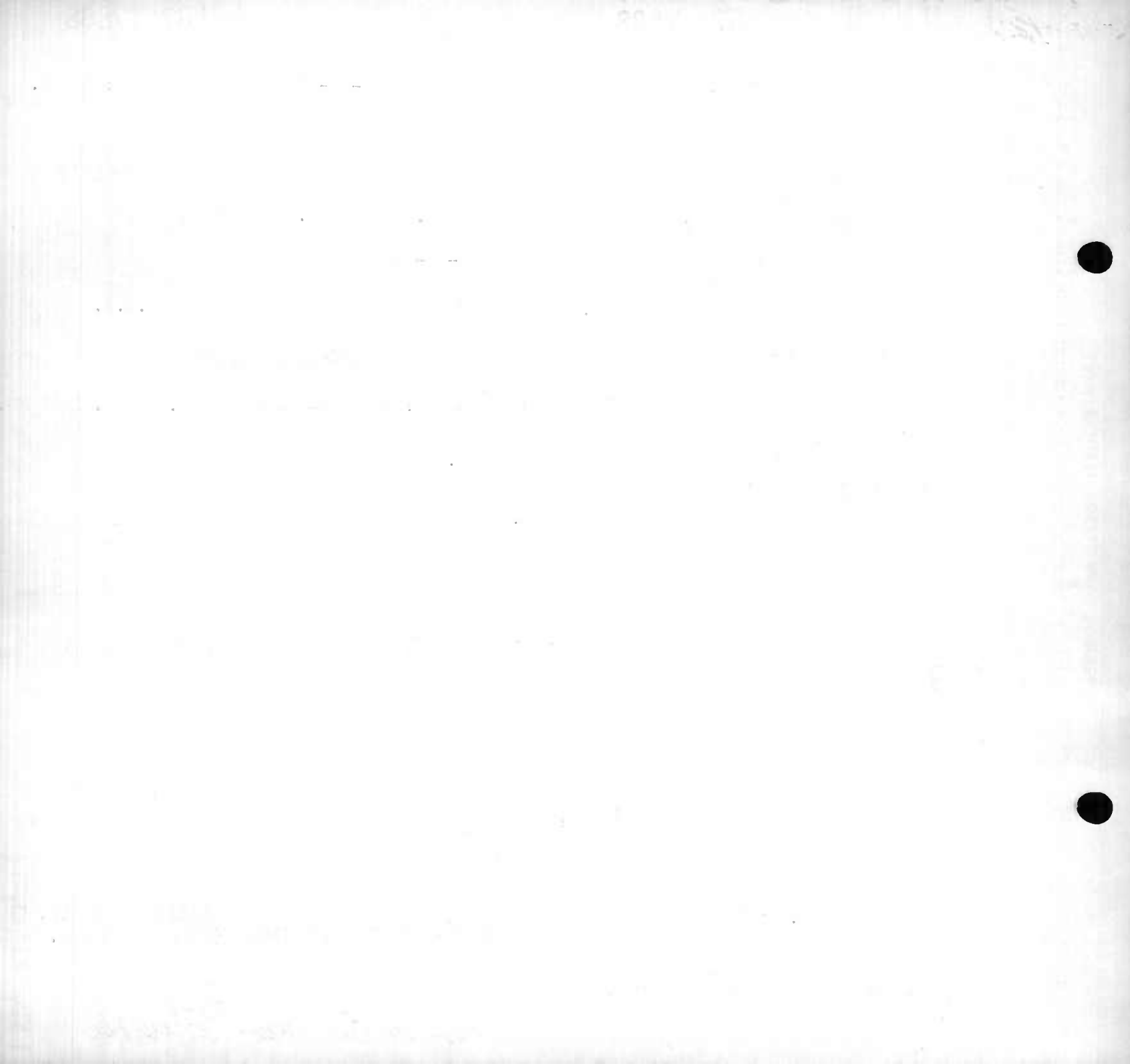
U. S. DISTRICT COURT

U. S. DISTRICT COURT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

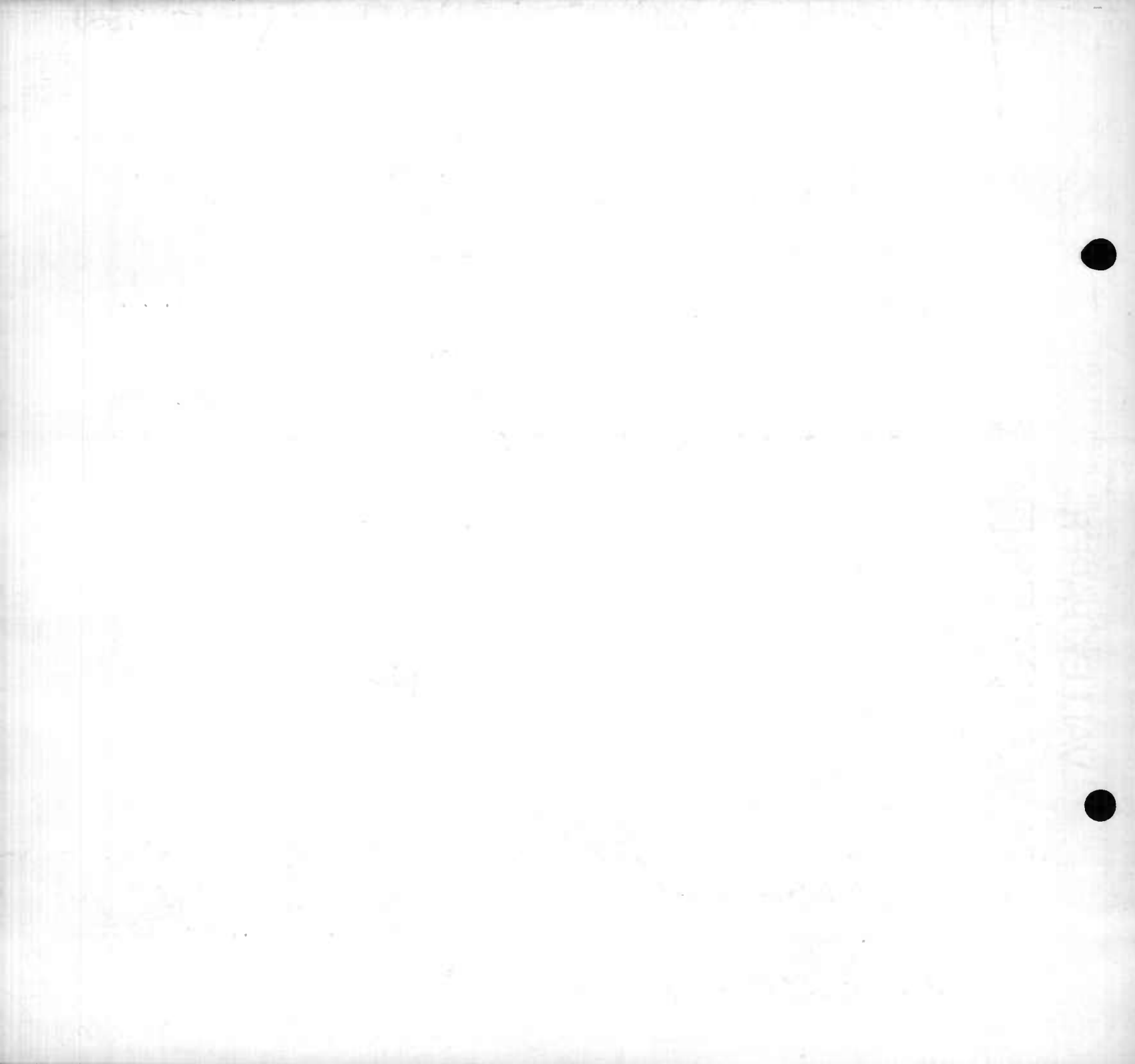
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7898		CERTIFICATE OF DEATH		67 7898	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
GLADYS ALKIRE			8-15-67		2:05 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND			A. STATE MARYLAND		
			B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
BALTIMORE 26-44			BALTIMORE 125 N. JANNEY ST.		
			21224		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	MARRIED	8-28-22	44	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cashier		HecHt Co.		PENNSYLVANIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JAKE PRESOCK			Brandhauer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		236-58-1454		RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224 MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) EMBOLI CVA		
			(B) RHD & prosthetic mitral valve		
			(C) 8 yrs symptoms from RHD valve replaced 1964.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
8/15/67		myocardial infarction		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (If in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				YES	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/11/67 to 8/15/67, that (I) (we) last saw the deceased alive on 8/15, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. LEONARD LIPPMAN LEONARD LIPPMAN					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				BALTIMORE 21224, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				8/18/67	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Cumberland				Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 17 1967		Robert E. Falkner		Lassabo Funeral Home	
				25D. ADDRESS	
				2401 Belair Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

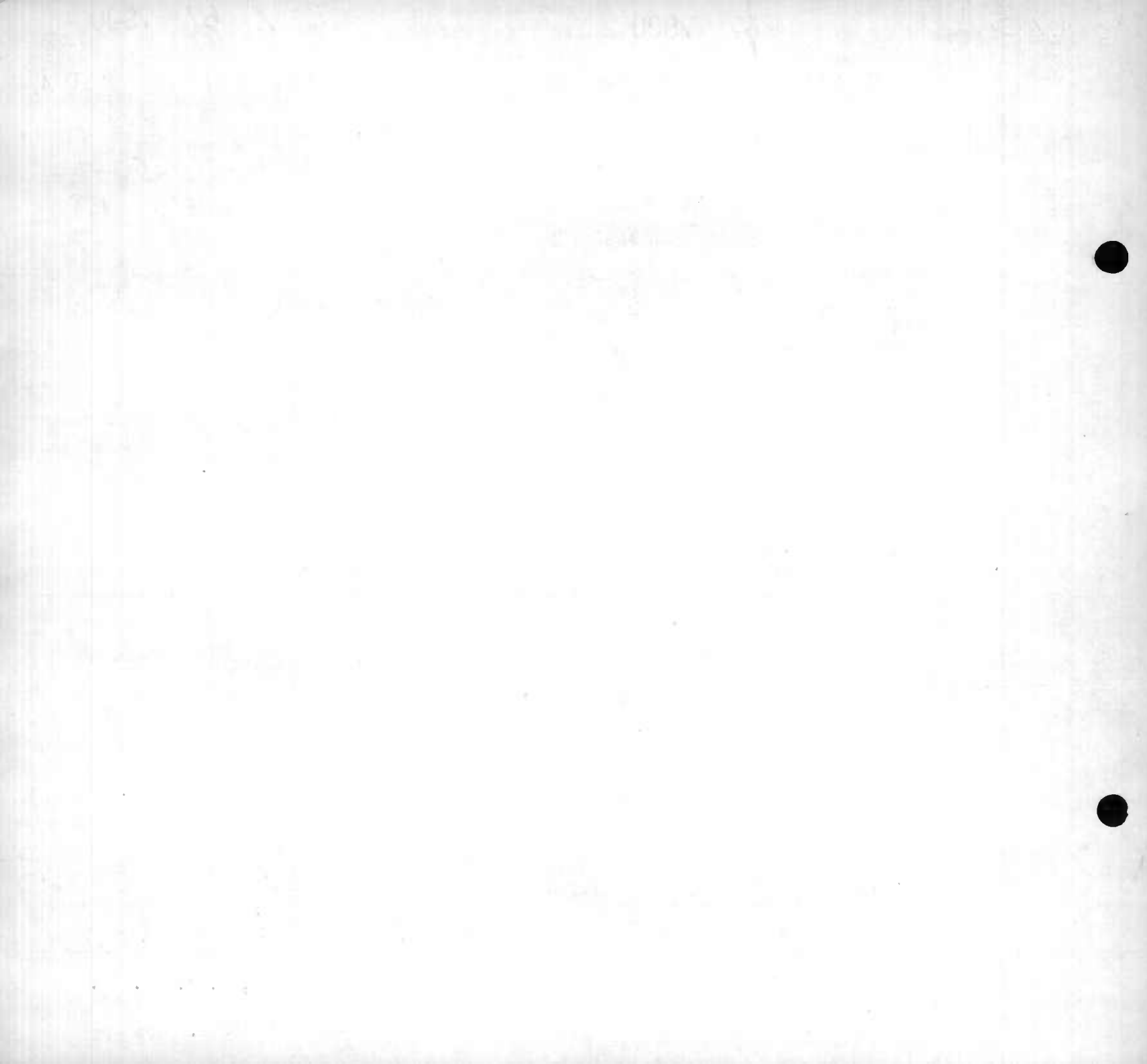
BIRTH NO. K-610 67 7899		BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 67 7899	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Ric By Helen</i>			
2. DATE AND HOUR OF DEATH <i>8-15-67 1 10³⁰ P.M.</i>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>A.A.C.</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Annapolis 52-10</i>				D. STREET ADDRESS (If rural, give location) <i>845 Spa Road 21401</i>			
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>6-26-06</i>	
9. AGE (In years last birthday) <i>61</i>		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>cab driver</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Taxi</i>			
13. FATHER'S NAME <i>Richard Brown</i>				14. MOTHER'S MAIDEN NAME <i>Perdella Brown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH- 4940 Eastern Ave. 21224</i>	
18. <i>224X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Medullary Failure</i>			
				(B) <i>Choriopharyngoma</i>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>8-8-67</i> to <i>8-15-67</i> , that (2) (we) last saw the deceased alive on <i>8-15-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>P. Desmond</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-15</i>	
23C. PHYSICIAN'S NAME (Type) <i>P. Desmond</i>				23D. ADDRESS <i>Baltimore City Hospitals 4940 Eastern Ave. Balto., Maryland 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-19-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Pine Lawn</i>		24D. LOCATION (City, town, or county) <i>Annapolis Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 18 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>William Reese</i>		ADDRESS <i>Annapolis</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

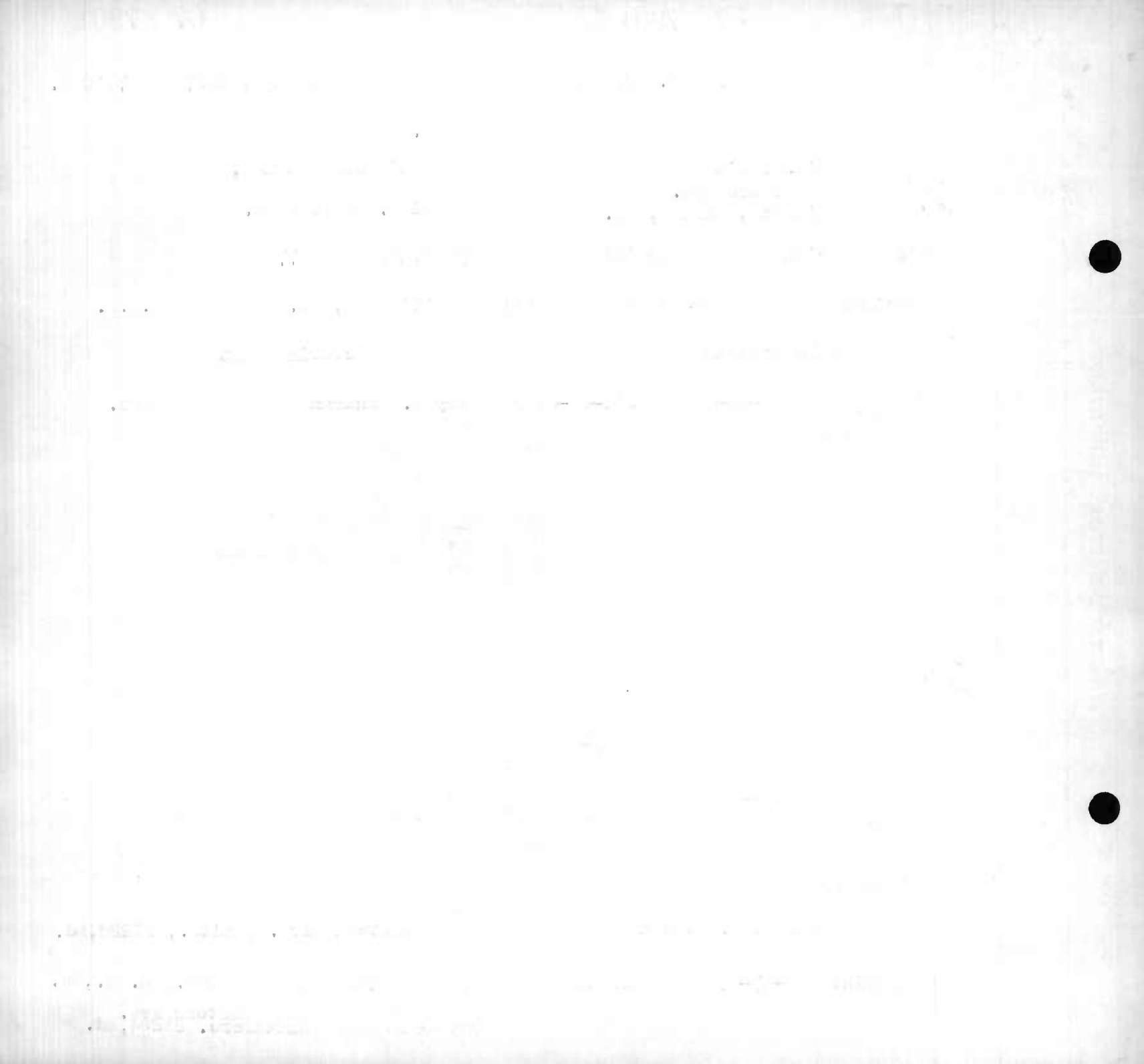
BIRTH NO. 67 7900		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7900	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GLADYS ELIZABETH BROPHY		2. DATE AND HOUR OF DEATH August 17 '67 10:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
		D. STREET ADDRESS (If rural, give location) 3821 ELKROFT RD.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-1-1892	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char Woman		10B. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES DITTY		14. MOTHER'S MAIDEN NAME DORCAS CLARK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-34-9510		17. INFORMANT Thomas Brophy (SON) 3821 Elkroft Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) CARCINO MATOSIS DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6 1967 to August 17 1967, that (I) (we) last saw the deceased alive on July 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-17-67	
23C. PHYSICIAN'S NAME (Type) A. MENDOZA		23D. ADDRESS M.D. Franklin Square Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8 21 67	24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Mc Gully 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7901	
BIRTH NO. 67 7901		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PHILIP J. VONTRAN		2. DATE AND HOUR OF DEATH August 13, 1967 7:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, 21224, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21224, 26-05			
		D. STREET ADDRESS (If rural, give location) 511 S. Rappola St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 31, 1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Cross and Blackwell		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John Vontran			14. MOTHER'S MAIDEN NAME Victoria Beltz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-0909		17. INFORMANT Mary L. Vontran	
				ADDRESS Same.	
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pulmonary Hemorrhage DUE TO (B) Pulmonary Embolism DUE TO (C) Anteriodissecting Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 1967 to Aug 7 1967 , that (I) was last saw the deceased alive on Aug 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel P. DeLeon				23B. DATE SIGNED 8/14/67	
23C. PHYSICIAN'S NAME (Type) Manuel P. DeLeon		23D. ADDRESS Eastern Blvd., Balto., 21224, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION 7225 Eastern Blvd., Ba. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Charles S. Zeller	
ADDRESS 6224 Eastern Ave. Baltimore, 21224, Md.					



K-400

67 7902

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7902

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY KAHL

2. DATE AND HOUR PRONOUNCED DEAD

August 15, 1967 7:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4288 Clydesdale Ave.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Nov 7 1923

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Binder

10B. KIND OF BUSINESS OR INDUSTRY

Book Publisher

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William E Fite

14. MOTHER'S MAIDEN NAME

Addie L. Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217142029

17. INFORMANT

John T Kahl

ADDRESS

4288 Clydesdale Ave

18.

330 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

X X X X X

Subarachnoid Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Berry aneurysm

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

August 16, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-18-67

23C. NAME OF CEMETERY or CREMATORY

Belto National

23D. LOCATION

Belto Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 18 1967

24B. NAME OF REGISTRAR

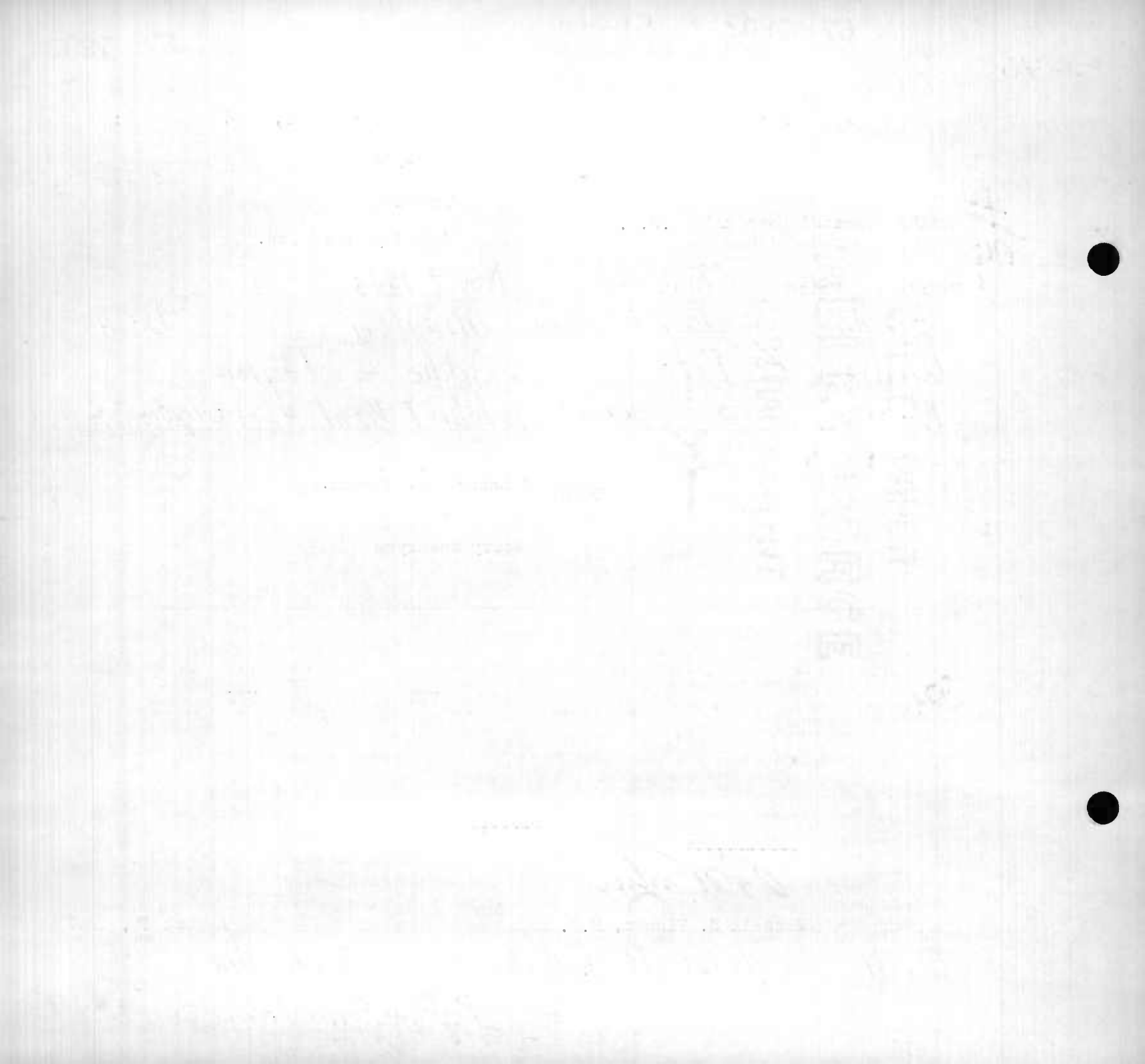
Robert E. Farber

24C. FUNERAL DIRECTOR

Burgess Funeral Home 3631 Falk Rd

ADDRESS

Ba Neria M. Burgess Jr



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7903				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7903	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				DAVIS, CHARLES E.		August 16, 1967 1 a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
33 Johns Hopkins Hospital				Baltimore		26-03	
D. STREET ADDRESS (If rural, give location)				3628 Elmley Avenue, Balto., Md.		21213	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
male	white	married	Jan. 1, 1904	63 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Occupational Therapist Sheppard Pratt Hosp.			Baltimore, Md.				U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Davis				Cora Flory			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no			219-01-5421		Harriet Davis (nee Pearson), wife, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		7 years	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				Emphysema			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 1967 to Aug. 16, 1967, that (I) (we) last saw the deceased alive on May 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Donald Jandorf						8-17-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Donald Jandorf				6077 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		8/19/67		Greenmount Crematory		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 18 1967		Robert E. Farkas		Schimunek Funeral Home		3331 Brehms Lane #13	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620		67 7904		Baltimore City Health Department		Registered No. 67 7904	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) BOWERS, GLENDORE E.			
2. DATE AND HOUR OF DEATH 16 AUGUST 1967 2:36 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 4902 Wright Avenue 21205							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/12/1908	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sullivan				14. MOTHER'S MAIDEN NAME Grace Preston White			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS George Bowers, husband, above Records: BCH-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS				INTERVAL BETWEEN ONSET AND DEATH 2ds			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION				9ds			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ATHEROSCLEROTIC CORONARY ART. DIS				YEARS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 8/7/67 to 8/16/67 and that (I) (we) last saw the deceased alive on 16 AUGUST 1967 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (the) view the body after death.							
23A. SIGNATURE Russell D Hicks				M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 16 AUGUST 1967	
23C. PHYSICIAN'S NAME (Type) RUSSELL D. HICKS				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/67		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 321 E. Johns Ave #13	

2000 1000 1000 1000 1000 1000 1000 1000 1000 1000

Atmospheric Corrosion
Microbial Infection
Purification Processes

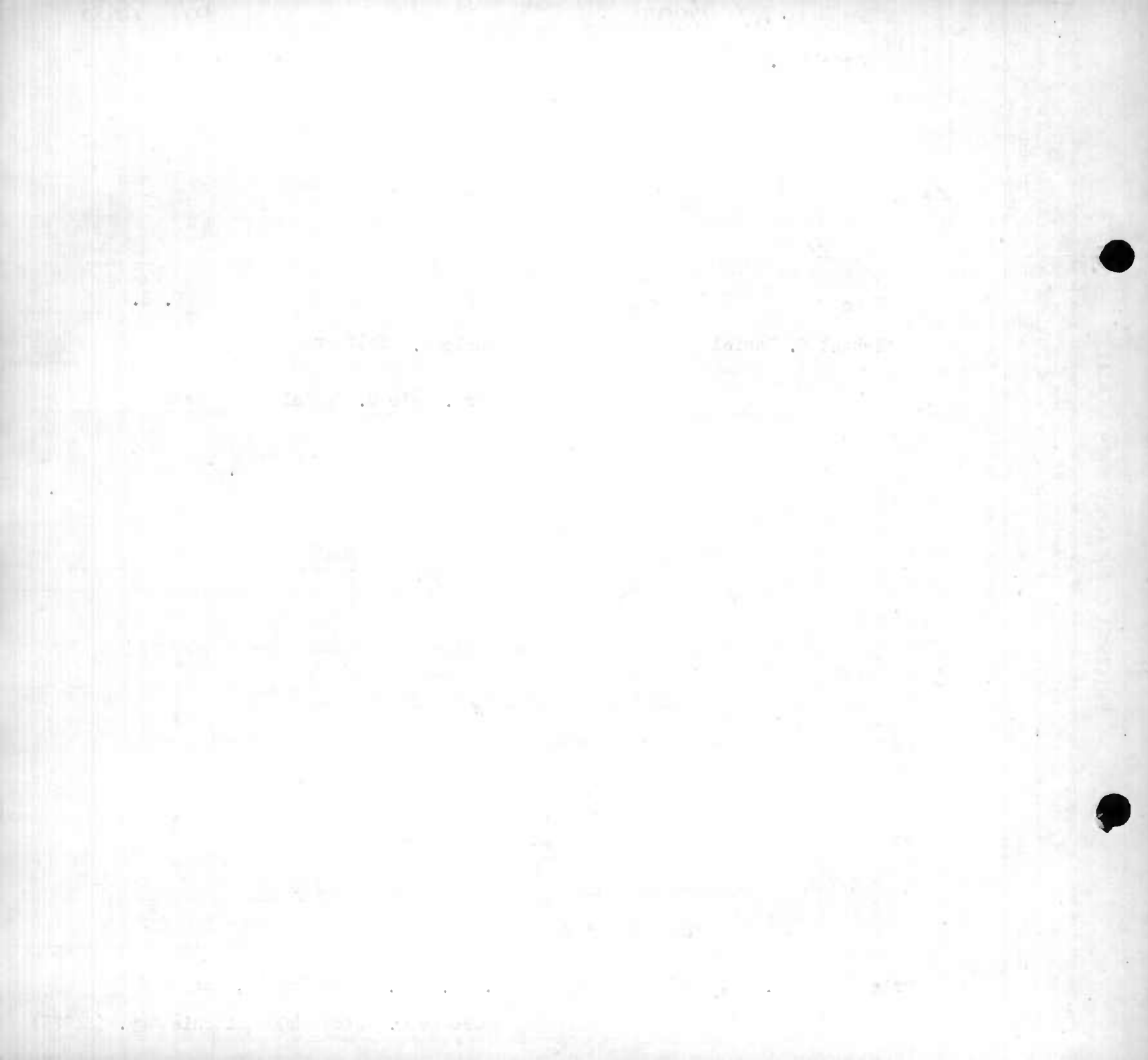
10

Russell D. Hicks
Russell D. Hicks
1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

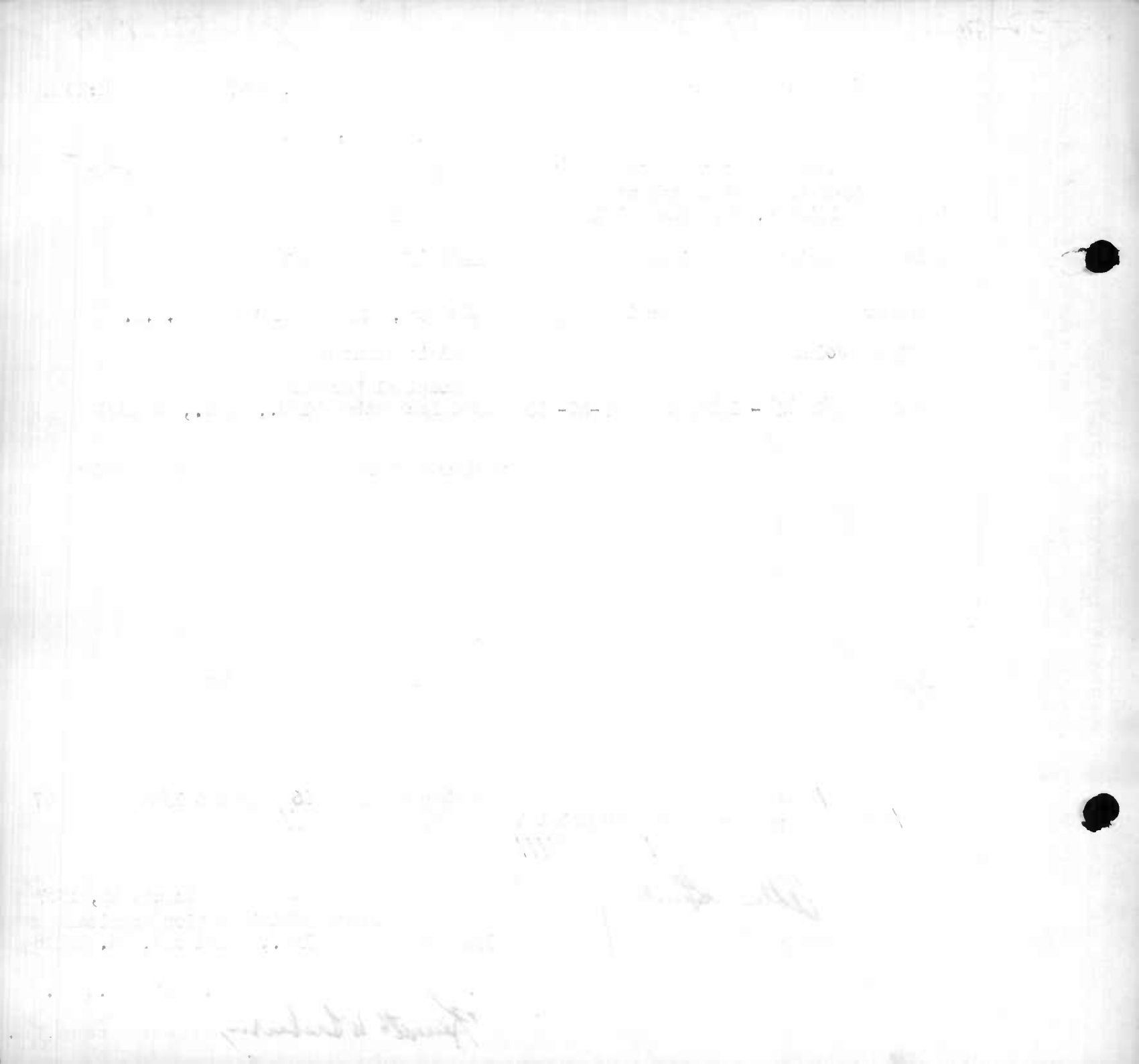
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-15907 67 7905</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 7905</u>	
M.E. CASE NO.		1. NAME OF DECEASED <u>Michael E. Daniel</u> <u>BABY GIRL DANIEL</u>		2. DATE AND HOUR OF DEATH <u>8-12-67</u> <u>7:30 a.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Anne Arundel Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>52-00</u> D. STREET ADDRESS (If rural, give location) <u>5719 Johnson Street</u>			
5. SEX <u>F.</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8-10-67</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Michael E. Daniel</u>			14. MOTHER'S MAIDEN NAME <u>Gale D. Pfeiffer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Gale D. Daniel</u> ADDRESS <u>Same</u>	
18. <u>75-1-1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Meningoencephalitis</u> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>43 h. 30 min.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0 10</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-10-67</u> to <u>8-12-67</u> , that (I) (we) last saw the deceased alive on <u>8-12-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Milos Radojkovic</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8-12-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>MILOS RADOJKOVIC</u> M.D.		23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Aug. 14, 1967</u>	24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Mem. Pk. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George J. Gonce 4001 Ritchie Hwy. (21225)</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

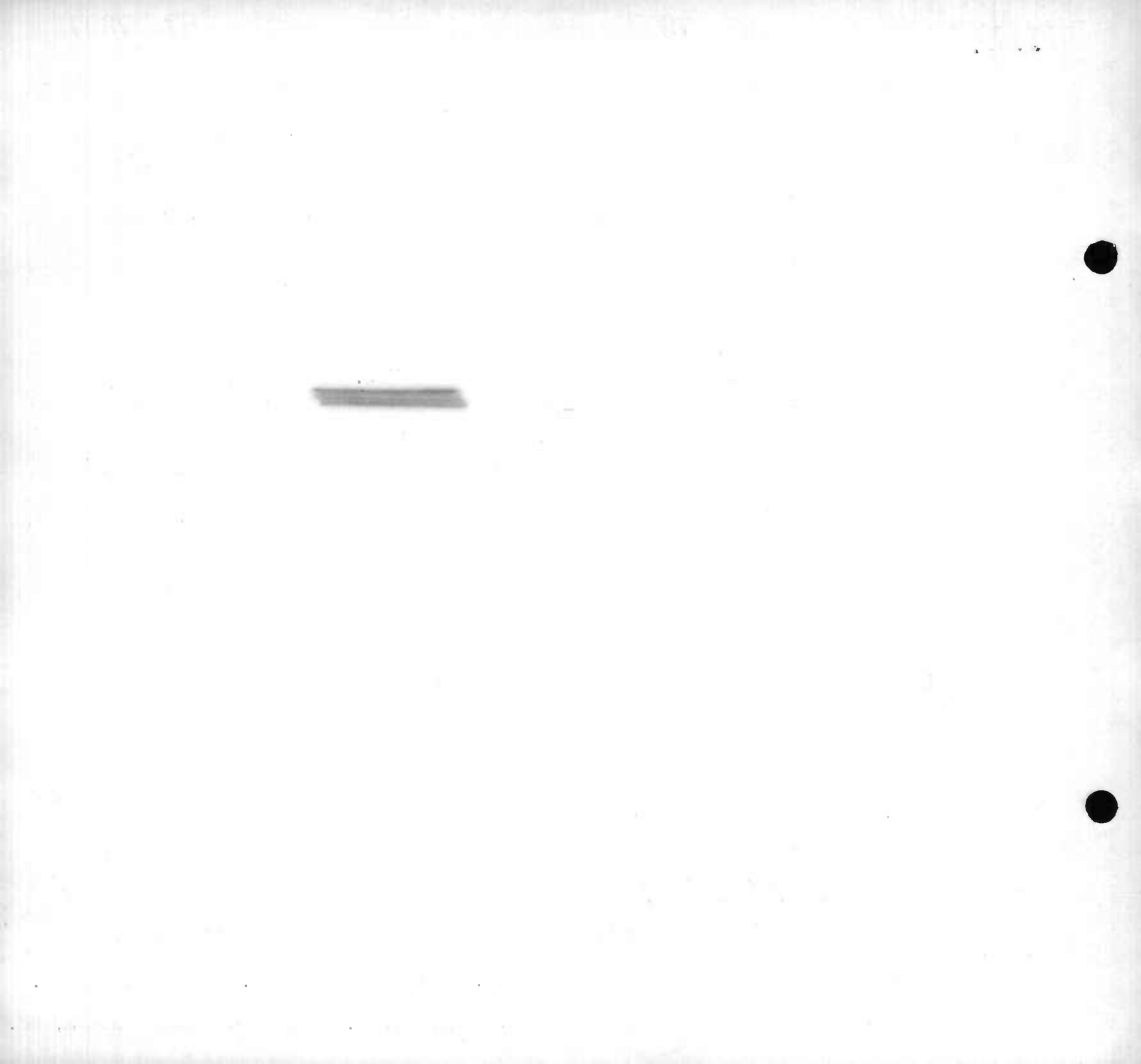
BALTIMORE CITY HEALTH DEPARTMENT											
67 7906					X Registered No. 67 7906						
BIRTH NO.					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH						
JOINES, Kyle Herbert					August 15, 1967 8:10 A M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY						
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218					Pennsylvania, York						
27					C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
					Felton						
					D. STREET ADDRESS (If rural, give location)						
					RD # 1						
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)			
Male		White		Divorced		11/26/13		53 3			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Farmer			Farming			Abshire, North Carolina			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Hilary Joines					Hallie Johnson						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
Yes 2/28/45 - 1/22/46					055-42-6338		VA Hospital Records			3900 Loch Raven Blvd., Balto., Md 21218	
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)										? 6 months	
(A) Carcinoma of tongue											
DUE TO											
2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(B) DUE TO											
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2								Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from December 12th 19 66 to August 15th 19 67, that (1) (we) last saw the deceased alive on August 15th 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (view) view the body after death.											
23A. SIGNATURE										23B. DATE SIGNED	
Allen Ginsberg										August 16, 1967	
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS	
ALLEN GINSBERG										Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Burial				8/17/67		Susquehanna Mem. Gardens Dallastown, York Co., Pa.					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
AUG 18 1967				Robert E. Johnson				Stewartstown, Pa.			



FUNERAL DIRECTOR: IMPORTANT

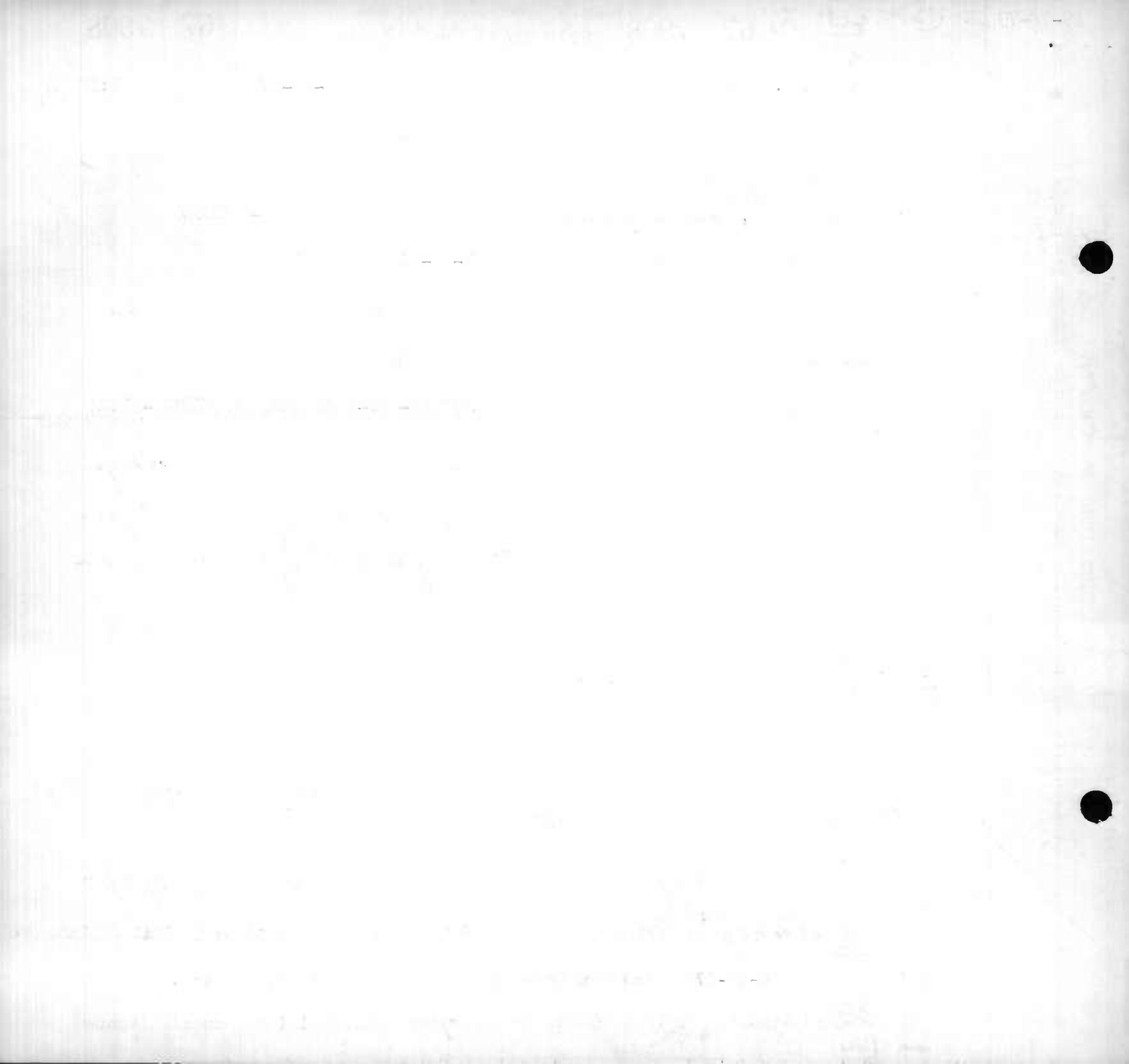
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7907				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7907	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				DR. CLYDE F. KARNIS		8-17-67 6:05A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland Maryland		A A	
34 Bon Secours Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Pasadena 52-00	
D. STREET ADDRESS (If rural, give location)				LARE Shore Drive		Box #124	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
M	W	MARRIED	12/4/00	66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SURGEON		M.D.		Maryland		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Reuben Karnis				Irene Garland.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		one 220-44-7920		rs. Elaine Karnis		(wife) Same as #4	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				YEARS			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Congestive Failure			
ANTECEDENT CAUSES				A S C V D			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				None			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-14 19 67 to 8-17 19 67, that (I) (we) last saw the deceased alive on 6:05AM. 8-17 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Byung Kap Kang				8-17-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
BYUNG KAP KANG				Bon Secours Hospital		2026 W. Fayette St. BALTO. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		August 21/67		Meadowridge Mem. Park		Howard Co. Elkridge, RFD Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 18 1967		Robert E. Taylor		Richard V. Singleton		Glen Burnie, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 0-520		67 7908		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7908	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) EDGAR V. OWENS			
2. DATE AND HOUR OF DEATH 8-15-67 3:50 A M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY X			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-36			
D. STREET ADDRESS (If rural, give location) 6215 SHIPVIEW WAY - 21224							
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-21-04	9. AGE (In years lost birthday) 63	10. Under 1 Yr. Months Days Hours Min.	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ERNEST				14. MOTHER'S MAIDEN NAME IDA MARTIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE-21224			
18. 502,01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) pneumonia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. chronic bronchitis & emphysema DUE TO Bleeding duodenal peptic ulcer DUE TO 25 years.				INTERVAL BETWEEN ONSET AND DEATH 12 days 17 years 25 years.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3 8/6/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED my distress tuberculosis		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, place bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7/24 19 67 to 8/15 19 67 , that (1) (we) last saw the deceased alive on 8/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard Lippman M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/15/67			
23C. PHYSICIAN'S NAME (Type) LEONARD LIPPMAN		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-67		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR Walter Dabrowski		ADDRESS 1005 Dundalk Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">67 7909</p> <p style="font-size: 18pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>		<p>Registered No. 67 7909</p>	
<p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) ANNA MAE PFINGST</p>		<p>2. DATE AND HOUR OF DEATH 17th AUGUST 1967 5:10 AM.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY a.g.c. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 32-00 D. STREET ADDRESS (If rural, give location) 5706 GISCHEL STREET 21225</p>	
<p>5. SEX FEMALE</p>	<p>6. RACE White CAUCASIAN</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED</p>	<p>8. DATE OF BIRTH 8-01-98</p>
<p>9. AGE (In years lost birthday) 69</p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY —</p>	
<p>11. BIRTHPLACE (State or foreign country) MARYLAND. (Baltimore)</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA.</p>	
<p>13. FATHER'S NAME WILLIAM HOLSTON</p>		<p>14. MOTHER'S MAIDEN NAME LUCY Morris</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN None</p>		<p>16. SOCIAL SECURITY NO. 216-07-7584</p>	
<p>17. INFORMANT DR. W. OEHLERT</p>		<p>ADDRESS UNION MEMORIAL HOSPITAL</p>	
<p>18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the Stomach (Mucinous Adenocarcinoma)</p> <p>II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION 8/10/67</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Weakness, anorexia, wt. loss</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (M) (this hospital) attended the deceased from July 24 1967 to August 17 1967, that (I) (we) last saw the deceased alive on 8/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (W) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE W. H. Oehlert, Jr.</p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) WILLIAM H. OEHLERT, JR., M.D.</p>		<p>23D. ADDRESS THE UNION MEMORIAL HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 8/19/67</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Oakland</p>		<p>24D. LOCATION (City, town, or county) (State) Balt Co. Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967</p>		<p>25B. NAME OF REGISTRAR Robert E. Johnson</p>	
<p>25C. FUNERAL DIRECTOR McCully Funeral Home</p>		<p>ADDRESS 3710 Patuxent Rd. Balt 21225</p>	

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL. 60637

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7910		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7910	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VALCOURT, CYRIL HENRY			2. DATE AND HOUR OF DEATH AUGUST 17, 1967 12:10A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL WILKENS AND CATON AVE BALTIMORE MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227 9-03		
			D. STREET ADDRESS (If rural, give location) 1229 GREYSTONE ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 09/22/98	9. AGE (In years lost birthday) 68 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Westunhouse Elec.	11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRANCIS VALCOURT			14. MOTHER'S MAIDEN NAME LEGRANARDE Emma Legranarde		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 015 03 7074		17. INFORMANT ADDRESS ST AGNES HOSPITAL WILKENS AVE 21229	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>600,01</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>UREMIA ; GASTROINTESTINAL BLEEDING</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>PYELONEPHRITIS</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p style="text-align: center;">HEART FAILURE</p>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 16 1967 to AUGUST 17 1967 , that (I) (we) last saw the deceased alive on AUGUST 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gabriela Braun</i>				23B. DATE SIGNED 8-17-67	
23C. PHYSICIAN'S GABRIELA BRAUN				23D. ADDRESS M.D. ST AGNES HOSPITAL WILKENS AVE 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-19-67	24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/15/01 BY 60322 UCBAW

DATE 10/15/01 BY 60322 UCBAW
REASON FOR DECLASSIFICATION
1.5X

DATE 10/15/01 BY 60322 UCBAW

DATE 10/15/01 BY 60322 UCBAW

DATE 10/15/01 BY 60322 UCBAW

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DATE 10/15/01 BY 60322 UCBAW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7911	
BIRTH NO. 67 7911		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Kaufman, Michael		2. DATE AND HOUR OF DEATH 8/15/67 4:05 4:05 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balt. City		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-06	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp.		D. STREET ADDRESS (If rural, give location) 2850 N. Charles St.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 01-05-04	9. AGE (In years last birthday) 63	12. CITIZEN OF WHAT COUNTRY? USA
10B. KIND OF BUSINESS OR INDUSTRY MUSIC		11. BIRTHPLACE (State or foreign country) Austria		13. FATHER'S NAME Leopold Kaufman	
14. MOTHER'S MAIDEN NAME Jenny Silverberg		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Frank B. Kaufman Same		ADDRESS		18. CAUSE OF DEATH Carcinoma Esophagus	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. INTERVAL BETWEEN ONSET AND DEATH		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/15 8/17 to 8/15 19 67 , that (1) (we) lost saw the deceased alive on 8/15 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BARRY J. WECKESSER		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) BARRY J. WECKESSER		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/67		24C. NAME of CEMETERY or CREMATORY MOUNT HOPE	
24D. LOCATION (City, town, or county) (State) HASTING ON HUDSON, NEW YORK		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR R. A. E. Kelly	
25C. FUNERAL DIRECTOR ADDRESS SOZ LEVINSON & BROS 6010 REISTERSTOWN RD.					

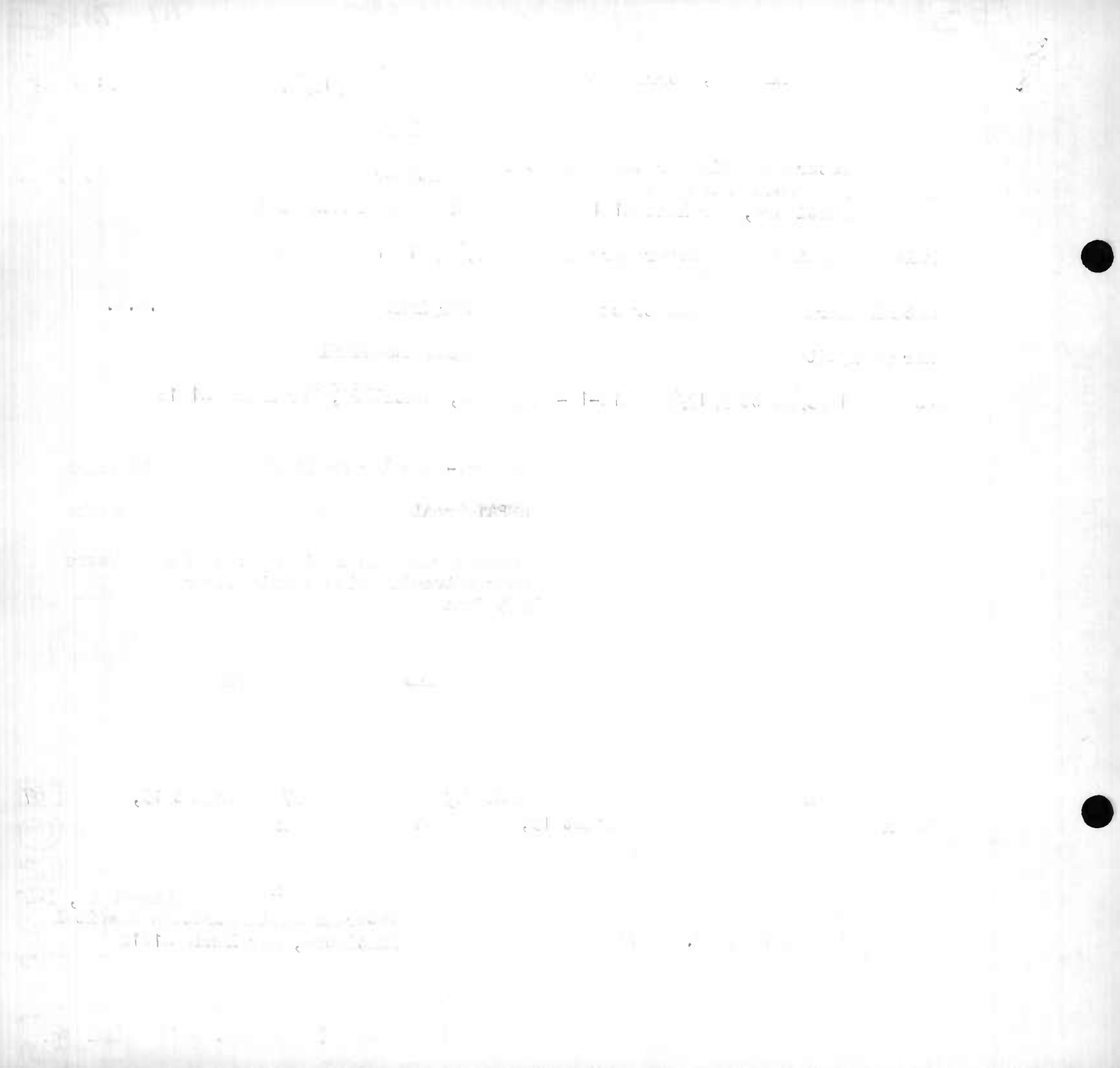
Commence Baptisms

JAN 20 1882

JAN 20 1882

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7912	
BIRTH NO. 67 7912				Registered No. 67 7912	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LIPSITZ, Morris NMI			8/15/67 5:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2606 Labyrinth Road		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 3/22/ 1901	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mutual Clerk		10B. KIND OF BUSINESS OR INDUSTRY Racetrack	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry Lipsitz			14. MOTHER'S MAIDEN NAME Leah Rosenthal		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/5/42 to 3/13/43		16. SOCIAL SECURITY NO. 212-16-9045	17. INFORMANT Records VAH, Baltimore, Maryland 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I Cerebro-vascular accident HEPATORENAL syndrome Arteriosclerosis obliterans of the lower extremity with stasis ulcer left foot			INTERVAL BETWEEN ONSET AND DEATH 20 hours 3 weeks Years		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from July 25, 19 67 to August 15, 19 67, that (he) (we) lost saw the deceased alive on August 15, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE ERNESTO R. SMITH				23B. DATE SIGNED August 16, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Veterans Administration Hospital Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/16/67		24C. NAME of CEMETERY or CREMATORY Mikro Kodesh Cemetery	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR OSOL LEVINSON & BROS INC. 6010 Reist. Rd.			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR J. J. E. (Faint)		25C. FUNERAL DIRECTOR OSOL LEVINSON & BROS INC. 6010 Reist. Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7913				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7913	
<div style="display: flex; justify-content: space-between;"> <div> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>MAX L. KESSLER</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>8/14/67</i> <i>8:49 PM</i></p> </div> </div>							
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI HOSPITAL</i> (If not in hospital or institution, give street address or location)</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>28-02</i> D. STREET ADDRESS (If rural, give location) <i>3128 Howard Park Ave.</i></p>			
<p>5. SEX <i>Male</i></p>	<p>6. RACE <i>White</i></p>	<p>7. MARRIED, NEVER MARRIED <i>Married</i></p>	<p>8. DATE OF BIRTH <i>Sept 23, 1915</i></p>	<p>9. AGE (In years last birthday) <i>51</i></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Director</i></p>	<p>11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i></p>	<p>12. CITIZEN OF WHAT COUNTRY? <i>USA</i></p>
<p>13. FATHER'S NAME <i>SAMUEL KESSLER</i></p>				<p>14. MOTHER'S MAIDEN NAME <i>ROSE MERMELSTEIN</i></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 2 Navy</i></p>				<p>16. SOCIAL SECURITY NO. <i>219-42-6002</i></p>		<p>17. INFORMANT <i>Mrs. Bernice Kessler-- Same</i></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Recurrent carcinoma of right colon carcinoma</i></p>				<p>INTERVAL BETWEEN ONSET AND DEATH <i>about 2 months</i></p>			
<p>19A. DATE OF OPERATION <i>8/17/67</i></p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>poor.</i></p>		<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>				<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>July 11 1967</i> to <i>August 14 1967</i>, that (I) (we) last saw the deceased alive on <i>August 14 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE <i>Terno Kawashima</i> M.D.</p>						<p>23B. DATE SIGNED <i>8/14/67</i></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>				<p>23D. ADDRESS <i>40 Sinai Hospital of Baltimore MD.</i></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i></p>		<p>24B. DATE <i>8/16/67</i></p>		<p>24C. NAME of CEMETERY or CREMATORY <i>King David Memorial Park</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Falls Church, Va.</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>AUG 18 1967</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Johnson</i></p>		<p>25C. FUNERAL DIRECTOR <i>SOE LEVINSON & BROS INC.</i></p>		<p>ADDRESS <i>6010 Reist Rd.</i></p>	

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FUNERAL DIRECTOR: IMPORTANT

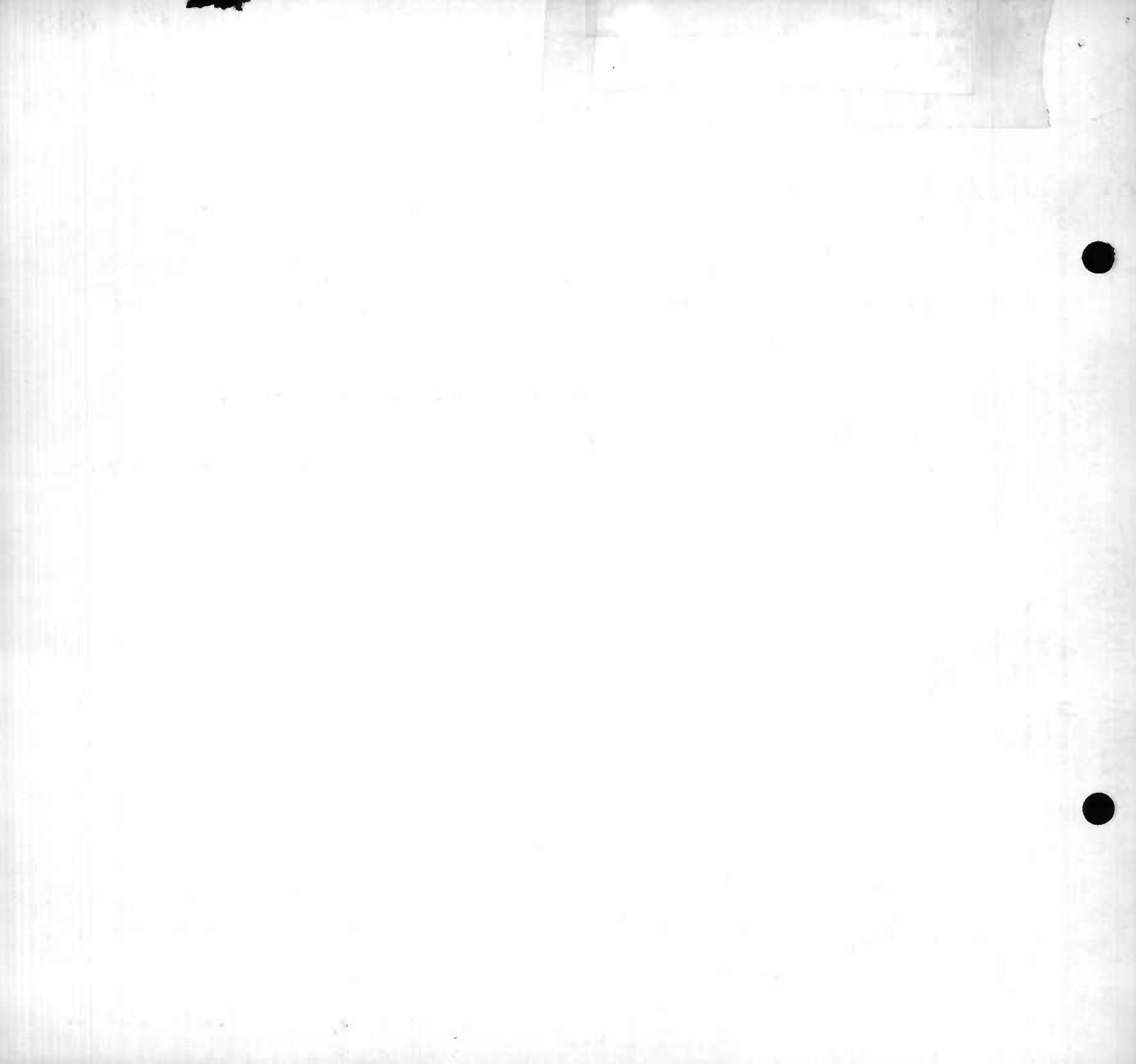
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7914	
BIRTH NO. 67 7914		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) YETTA ABELL		2. DATE AND HOUR OF DEATH 8/15/67 10:52 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		D. STREET ADDRESS (If rural, give location) 3800 Fordleigh Road		27-20	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 82	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown Dagold		14. MOTHER'S MAIDEN NAME Ida ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Nathan Abell- 6311 Wallis Avenue	
18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 13 days many years many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic Pyelonephritis		many years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/9 19 67 to 8/15 19 67 , that (I) (we) last saw the deceased alive on 8/15/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Katon				23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) RICHARD KATON				23D. ADDRESS 303 SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 16/67		24C. NAME OF CEMETERY or CREMATORY Anshe Emunah	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967			
25B. NAME OF REGISTRAR Paul E. Taylor		25C. FUNERAL DIRECTOR So. Levinson & Bros, Inc. 6010 Reisterstown Rd			

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

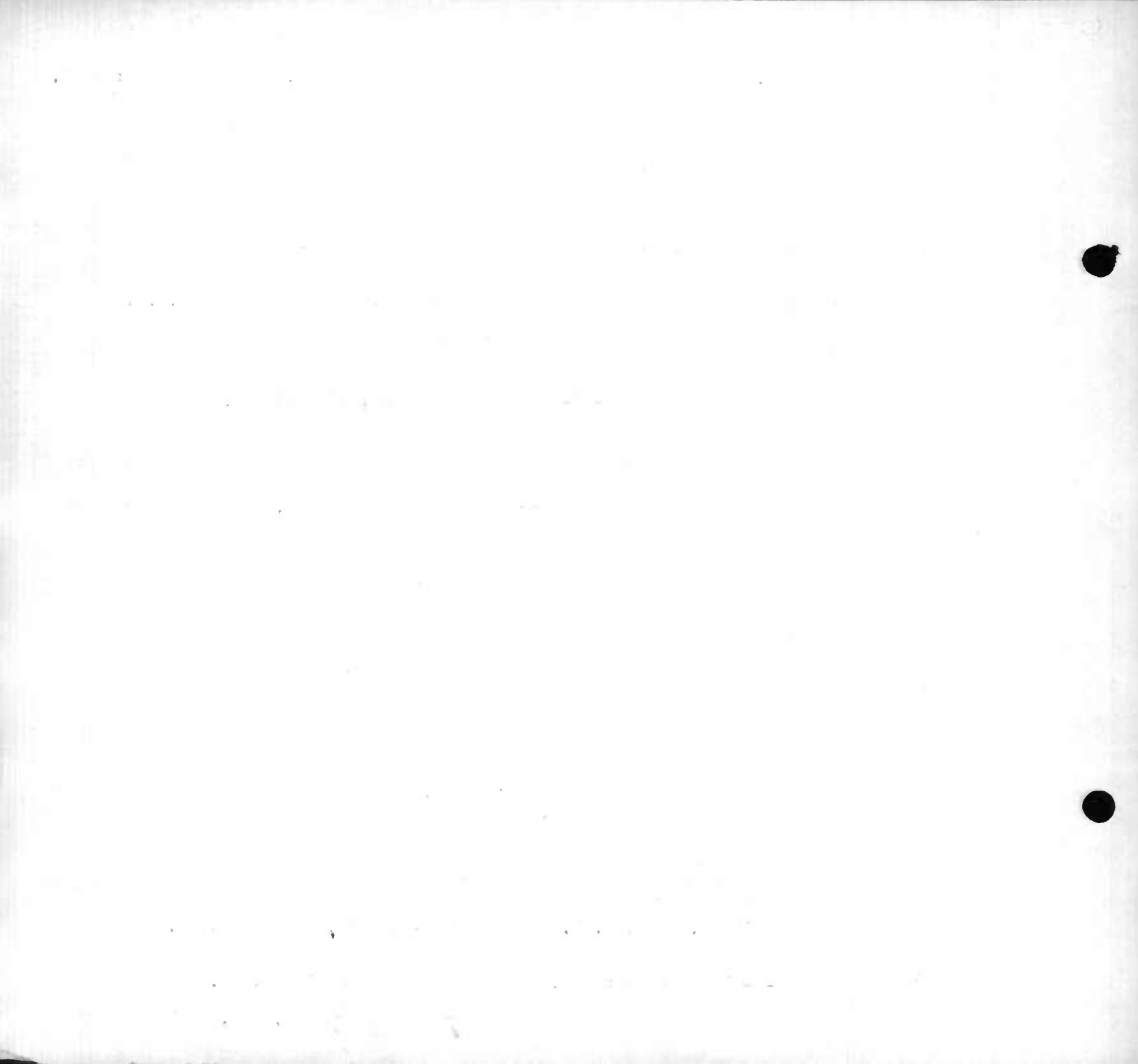
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7915	
<div style="display: flex; justify-content: space-between;"> 67 17815 67-7915 </div>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>David Brill</u>			2. DATE AND HOUR OF DEATH <u>August 16, 1967</u> <u>4:33</u> <u>A</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore, Inc.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>3614 Marmon Avenue</u>			<u>28-41</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/17/21</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TOBACCO & CANDY</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ABE BRILL</u>			
14. MOTHER'S MAIDEN NAME <u>SADIE FISHER</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>YES</u> <u>WW @ 2 Army</u>	
16. SOCIAL SECURITY NO. <u>215-14-4821</u>		17. INFORMANT ADDRESS <u>Mrs. Mindy Brill -- same</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Atherosclerotic heart disease</u>			CAUSE OF DEATH (A) <u>Acute myocardial infarction</u> DUE TO (B) <u>Atherosclerotic heart disease</u> DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>August 14</u> 19 <u>67</u> to <u>August 16</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>August 16</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Benjamin Knopsky</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>Aug. 16, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Benjamin Knopsky</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore, Inc.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/17/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Noses Montifiare</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Garber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS INC. 6010 Reist Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7916		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7916	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JULIAN A. WATSON		2. DATE AND HOUR OF DEATH August 1, 1967		6:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Turners Station, Maryland Balt Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Turners Station 53-00 D. STREET ADDRESS (If rural, give location) 131 Oak Street #22			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/5/1901	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Appomattox, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gus Watson			14. MOTHER'S MAIDEN NAME Mattie Gough				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-6607		17. INFORMANT Mary Watson, 131 Oak Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis Arteriosclerotic Heart D.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 hours 6 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Peptic Ulcer							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19, 1945 to August 1, 1967 that (I) (we) last saw the deceased alive on August 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William C. Wade				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED August 3, 1967	
23C. PHYSICIAN'S NAME (Type) William C. Wade, M.D.				23D. ADDRESS 140 Oak Avenue, Baltimore, Md. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett Fun. Home, 1701 Laurens		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7917		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7917	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) CATHERINE LOUISE ROCHE			8-11-67 9 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE		
5. SEX FEMALE			6. RACE WHITE		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED			8. DATE OF BIRTH 12-20-89		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME JAMES ROCHE			14. MOTHER'S MAIDEN NAME CATHERINE MCCABE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-44-1138		
17. INFORMANT			ADDRESS		
18. 330 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) SUBARACHNOID HEMORRHAGE 5 DAYS		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 6 19 67 to AUGUST 11 19 67, that (I) (we) last saw the deceased alive on AUGUST 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. E. Cathey			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUGUST 11, 1967
23C. PHYSICIAN'S NAME (Type) B. E. CATHEY			23D. ADDRESS THE UNION MEMORIAL HOSPITAL, UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial Aug. 14, 1967				Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		R. E. Taylor		Frank H. Newell, Pikesville, Md.	

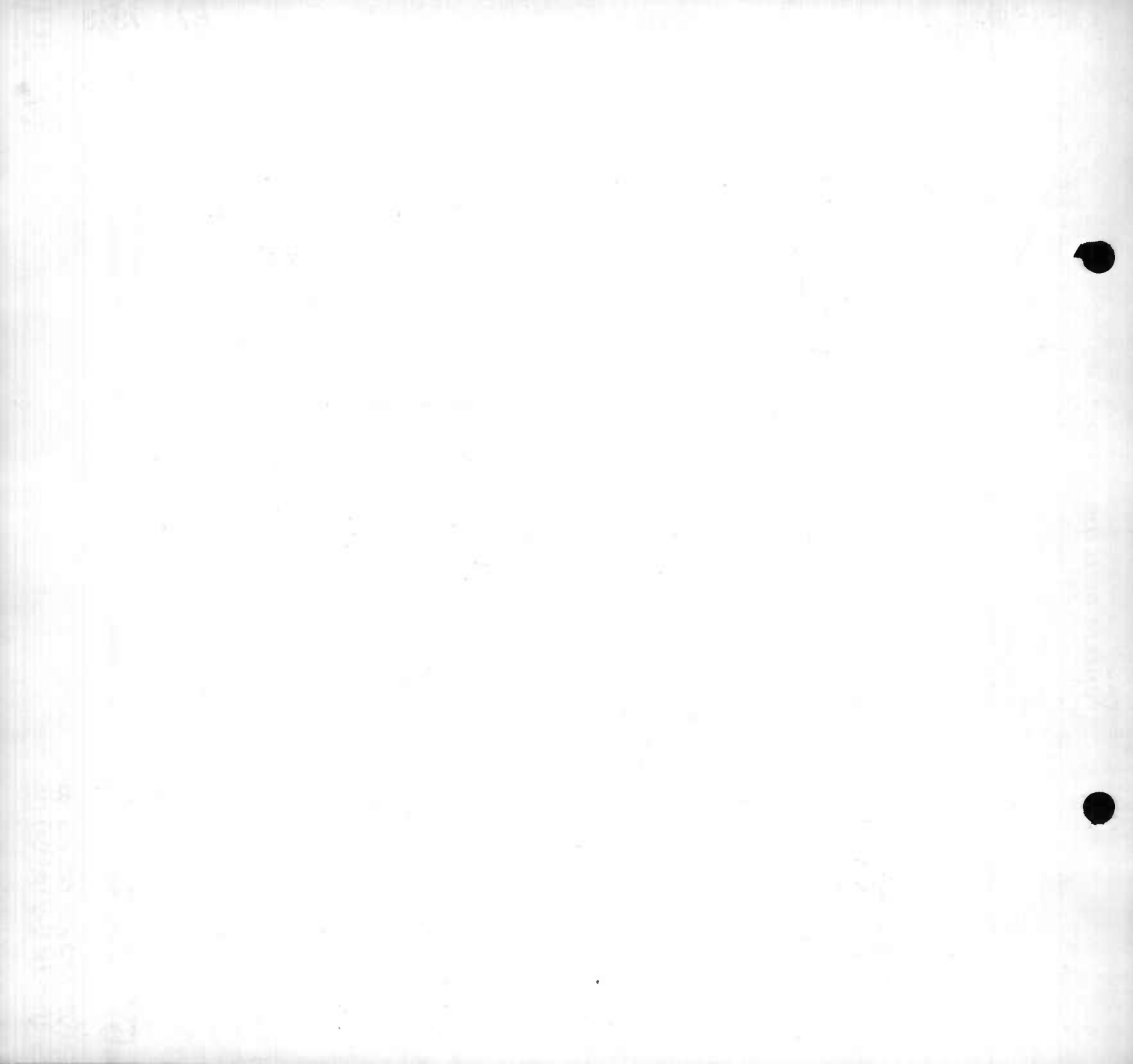
THE UNITED STATES OF AMERICA

CV 111-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 7918		67 7918		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				MICHAEL SAWCHUK	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
AUG 15 1967 8:00 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
		HOUSE OF THE PINES NURSING HOME BELAIR RD		MARYLAND	
5. SEX		6. RACE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
MALE		WHITE		BALTIMORE	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
NEVER MARRIED		11-1-1891		78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
WHEEL INSPECTOR		NEW YORK CITY		RUSSIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
NIRON SAWCHUK		TAKLA UNK.		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
YES WORLD WAR I		050-09-9785		WALTER PERKOWETZ 2419 KENTUCKY AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334X1		Multiple Decubitus ulcers		> 6 mo.	
ANTECEDENT CAUSES		(B) Flexion Contractures		year.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Multiple Strokes		year.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 62 to Aug 15 1967, that (I) (we) last saw the deceased alive on Aug 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED AUG 17 1967	
23C. PHYSICIAN'S NAME (Type) ALBERT B BRADLEY M.D.				23D. ADDRESS 4900 BELAIR ROAD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		AUG 18 1967		HOLY TRINITY CEMETERY	
				ELK RIDGE MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 18 1967		Albert B. Bradley		DIPLOMA 1800 E LOMBARD ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if ~~not~~ occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7919		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7919	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BARBARA STREB		2. DATE AND HOUR OF DEATH 8-16-67 9:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 412 N. CHAPEL ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-3-84	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME BARON PENCRASTIS			14. MOTHER'S MAIDEN NAME BARBARA ROY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-14-5100		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic CVA with aortic stenosis ? - many years.				(A) DUE TO Anemia & hyperkalemia		INTERVAL BETWEEN ONSET AND DEATH ?	
(B) DUE TO Chronic lymphocytic leukemia		(C)				3 years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-16-67 to 8-16-67, that (I) (we) last saw the deceased alive on 8-16-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Christopher B. Merritt				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8.16.67	
23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt				23D. ADDRESS Johns Hopkins Hosp. Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Aug 21/67		24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Philip Herwig Sons		25D. ADDRESS 2024 Adams St.	



FUNERAL DIRECTOR: IMPORTANT

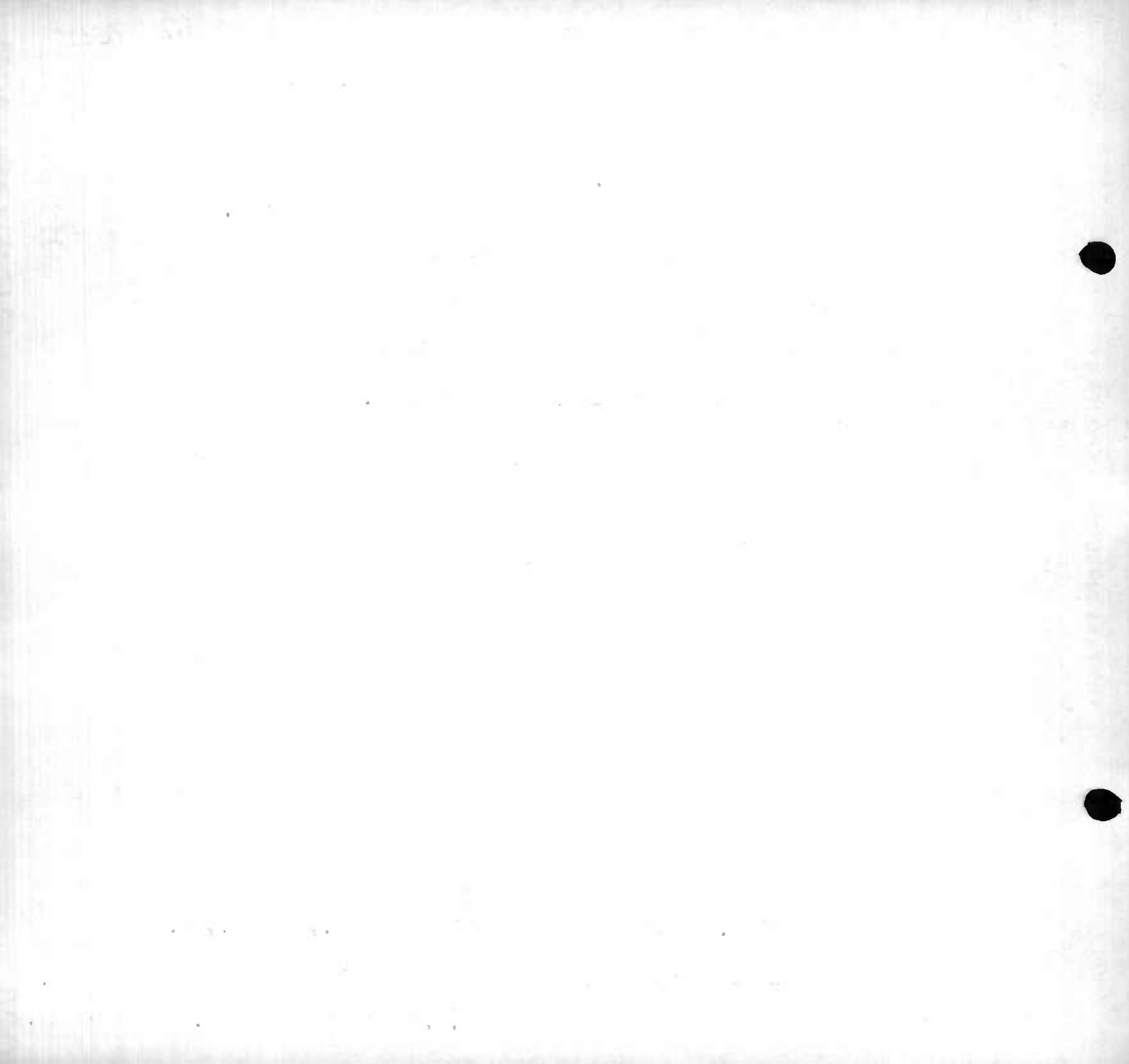
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
OLZEWSKI, MARY		8/17/67 10 ²⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2304 Boston Street 21231	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 6-3-20
9. AGE (In years last birthday) 47		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Waitress		Tavern	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Pennsylvania		U.S.A.	
13. FATHER'S NAME Walter Shostek		14. MOTHER'S MAIDEN NAME Anna Ponderak	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-5325	
17. INFORMANT Records-BCN 4940 Eastern Ave. Balto., Md.		ADDRESS 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Colon DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH 2 years 4 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7/24 1967 to 8/17 1967, that (1) (last) last saw the deceased alive on 8/17 1967 and that in my (1) opinion death occurred on the date and hour and from the causes stated above (1) (did) (view) the body after death.			
23A. SIGNATURE Jack Brandes		23B. DATE SIGNED 8/17/67	
23C. PHYSICIAN'S NAME (Type) Jack Brandes		23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224 M.D. Baltimore City Hospitals	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/67	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR George A. Weber		ADDRESS 705 S. Ann Street #21231	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7921	
BIRTH NO. 67 7921		CERTIFICATE OF DEATH		6:00 A.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Angela Sagoulas		2. DATE AND HOUR OF DEATH Aug. 16, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 3512 Greenmount Ave.		D. STREET ADDRESS (If rural, give location) 3512 Greenmount Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-12-1889	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressfitter		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? Greece		13. FATHER'S NAME George Mentis		14. MOTHER'S MAIDEN NAME Penelope ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-0790A		17. INFORMANT Steven G. Stamas	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic Vascular Disease 10 yrs.		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO Uterine Fibroid Tumor			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 10 1966 to Aug 16 1967 that (I) (we) last saw the deceased alive on Aug 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl F. Benson M.D.				23B. DATE SIGNED Aug 16, 1967	
23C. PHYSICIAN'S NAME (Type) Carl F. Benson		23D. ADDRESS M.D. 5111 York Rd., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-67		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox	
24D. LOCATION (City, town, or county) Baltimore				24E. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Glen E. Fisher		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 67 7922		67 7922				CERTIFICATE OF DEATH				Registered No. 67 7922	
1. NAME OF DECEASED (Type or Print) John Joseph Connelly						2. DATE AND HOUR OF DEATH 8-17-67					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3822 Tudor Arms Avenue						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3822 Tudor Arms Avenue					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12-4-1896	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Ret'd				10B. KIND OF BUSINESS OR INDUSTRY Matting Lumber Co. Massachusetts		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Connelly				14. MOTHER'S MAIDEN NAME Ellen Flynn							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 215-07-9973		17. INFORMANT Mrs. Mary E. Connelly		ADDRESS Same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Aug 15 1967 to Aug 19 1967 and that (I) (we) last saw the deceased alive on Aug 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE W. G. Helfrich						M.D. <input checked="" type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 18, 67			
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich M.D.						23D. ADDRESS 5006 Roland Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md.					

100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7923		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7923	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM L. SHOEMAKER, SR.		2. DATE AND HOUR OF DEATH 8/17/67 (THUR) 8:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY CHARLES ST C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD 21230 D. STREET ADDRESS (If rural, give location) 2302			
5. SEX Male	6. RACE White	7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)) MARRIED	8. DATE OF BIRTH 3-12-1902	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10B. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM SHOEMAKER		14. MOTHER'S MAIDEN NAME Jennie Keefe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES ARMY		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT MAE L. SHOEMAKER (Wife) ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1. Cerebral Hemorrhage - 7 days 2. Arteriosclerosis 3. Hypertensive Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-11 19 67 to 8-17 19 67 that (I) (we) last saw the deceased alive on 8-17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hector L. Feliciano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-17-67	
23C. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO		23D. ADDRESS M.D. FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug 22-67		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CATHOLIC	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		24E. NAME OF FUNERAL DIRECTOR CURTIS E. EVANS			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. ADDRESS 4005 CHARLES ST 21230	

10-10-1918

10-10-1918

10-10-1918

10-10-1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7924		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7924	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM GEBHARDT		2. DATE AND HOUR OF DEATH Aug. 17, 1967 11:42 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 636 S. Potomac St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH Dec. 10, 1905	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Calvert Drug Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Joseph Gebhardt		14. MOTHER'S MAIDEN NAME Sarah O'Bryan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 343814		17. INFORMANT ADDRESS John Gebhardt 532 Hurley Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 491X I Pleural effusion 2° to pneumonia Chronic asthmatic bronchitis Congestive Heart Failure		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II Peptic ulcers.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 8 19 67 to Aug 17 19 67 that (I) (we) last saw the deceased alive on Aug 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar Jr.				23B. DATE SIGNED 8/17/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR JR.				23D. ADDRESS CHURCH HOME & Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-1967		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7925

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)EDWARD JOSEPH ~~XXXXXXXX~~ FINNEGAN

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1967 1:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

821 Eutaw St. Apt 5

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Divorced

8. DATE OF BIRTH

Feb. 26, 1893.

9. AGE (In years
last birthday)74 ~~xxx~~If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Machinist

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

William J. Finnegan

14. MOTHER'S MAIDEN NAME

Mary Ellen Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
Unk.

17. INFORMANT

ADDRESS

Mrs. John J. Kresslein, Sr. 3511 Parklawn Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE*Russell S. Fisher*

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S

NAME (Type) Russell S. Fisher, M.D.

August 16, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/19/67.

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 18 1967

24B. NAME OF REGISTRAR

Robert E. Fairman

24C. FUNERAL DIRECTOR.

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

Feb. 26, 1953
New Virginia
Very Warm

Mr. John G. Kneeland, Jr., 1011

March

United Nations

William J. Kneeland

Mr.

Mr.

Mr. Kneeland

Mr. Kneeland

Mr. Kneeland

Mr. Kneeland

Mr. Kneeland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7926		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7926	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) JAMES Wm. TANNER			2. DATE AND HOUR OF DEATH 8/17/67 9:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21218 12-03 D. STREET ADDRESS (If rural, give location) 313 E. 27th St.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/28/77	9. AGE (In years, last birthday) 89	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED -- Ship Worker -- Bay Boats		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY J. TANNER			14. MOTHER'S MAIDEN NAME Susan COLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-2588		17. INFORMANT MRS. MARY TANNER ADDRESS 313 E. 27 St. BALTO.	
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) NEUMONIA. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pleural / body blood			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 10 19 67 to August 17 19 67 , that (I) (we) last saw the deceased alive on August 17 19 67 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Cipriani			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/67
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI			23D. ADDRESS THE UNION MEMORIAL HOSPITAL 33rd and CALVERT ST. BALTO.		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR Robert E. Ferguson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



STAIN
REMOVED

5-11-72

11-11-72

THE JOURNAL OF THE

AMERICAN

11-11-72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7927</u>	
BIRTH NO. <u>67 7927</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Marie A. Smith</u>		2. DATE AND HOUR OF DEATH <u>8/17/67</u> <u>4:20 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>		A. STATE <u>Md.</u>		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		<u>27-06</u>	
		D. STREET ADDRESS (If rural, give location) <u>5312 Grindon Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>82</u> <u>12/5/88</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stenographer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-5306</u>		17. INFORMANT <u>Mrs. John Hook</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pseudomonas aeruginosa</u> <u>septicemia</u>		CAUSE OF DEATH (A) DUE TO <u>Pneumonia</u> (B) DUE TO <u>Pancytopenia (etiology undetermined)</u> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>2 months</u>	
19. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED Wife At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from <u>7/4</u> 19 <u>67</u> to <u>8/17</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>8/17</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis E. Grenzer</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/17/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Louis E. Grenzer</u>		23D. ADDRESS <u>Mercy Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/21/67</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR, ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>			

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67 7928 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7928

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) KATHERINE M.		2. DATE AND HOUR PRONOUNCED DEAD August 14, 1967 5:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 612 E. Evesham Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 27-48 D. STREET ADDRESS (If rural, give location) 612 E. Evesham Avenue	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH March 15, 1900.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 67 xx
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. M. Vrabel, 28 Godfrey Place, Cresskill, New Jersey, 07626		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 8/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/15/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Cremation		23B. DATE 8/18/67.	
23C. NAME OF CEMETERY or CREMATORY Greenmount Crematory		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	
24C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

March 12, 1907

Madam

Dear

Friend

Housewife

Unknown

Unknown

Mrs. J. Vinet, 28 Bedford Place,
Greenwich, New Jersey, U.S.A.

Unknown

to

March 12, 1907

Respectfully

Yours

Unknown

Forwarded by mail, March 12, 1907

BIRTH NO.		67 7929		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 7929		
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR PRONOUNCED DEAD					
G. LAWRENCE SAKIEVICH x					August 16, 1967 7:30 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY					
Union Memorial Hospital					Maryland					
					C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)					
					Baltimore 21206 26-02					
					D. STREET ADDRESS (If rural, give location)					
					4819 Pleasant View Avenue					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		White		Single		October 9, 1949.		17		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Student				Maryland		USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
George J. Sakievich					LaVeta L. Bantner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No					217-50-4609		Mr. George J. Sakievich		(Same)	
18. CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										
(A) DUE TO Cerebrocranial injuries										
ANTECEDENT CAUSES										
(B) DUE TO										
(C) DUE TO										
INTERVAL BETWEEN ONSET AND DEATH										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
8-10-67		Head injury		Yes		Yes				
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)				
		School		Vocational School #420		3000 Loch Raven Boulevard				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Struck with iron roller during altercation						
8-10-67 2:40 P.										
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Charles S. Springate, M.D.					ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
					DATE SIGNED					
					August 17, 1967					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)				
Burial		8/21/67.		Baltimore National Cemetery		Baltimore, Md.				
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS				
AUG 18 1967		Robert E. Farber, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214						

October 3, 1944

Info

Present

George J. Seligman

James H. Dwyer

211-0-200 Mr. George J. Seligman (Info)

Re

George J. Seligman

Info

James H. Dwyer, 211-0-200, Mr. George J. Seligman, Info

George J. Seligman, 211-0-200, Mr. James H. Dwyer, Info

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7930				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7930	
1. NAME OF DECEASED (Type or Print) <u>Mr. Loyd. Hutson.</u>				2. DATE AND HOUR OF DEATH <u>8-15-67</u> <u>6:50</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON SECOURS HOSPITAL</u> <u>2025 W. FAYETTE ST.</u> <u>BALTO., MD. 21223</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>11-01</u> D. STREET ADDRESS (If rural, give location) <u>1125 St. Paul St.</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married.</u>	8. DATE OF BIRTH <u>9-18-77</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher & (Musician)</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		
12. CITIZEN OF WHAT COUNTRY? <u>yes</u>			13. FATHER'S NAME <u>Charles Hutson.</u>				
14. MOTHER'S MAIDEN NAME <u>Reus</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. I</u>				
16. SOCIAL SECURITY NO. <u>218-22-8724</u>			17. INFORMANT ADDRESS <u>Mrs. Helen C. Hutson XXX 1125 St Paul St.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>154X I</u> <u>Severe dehydration & anoxia 1 week?</u> <u>due to septicemia?</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>(C) Metastatic Ca of the testis Unknown.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug -12-</u> 19 <u>67</u> to <u>Aug -15-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug -15-</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dong Sup Cha</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug -15-1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONG SUP CHA</u>				23D. ADDRESS M.D. <u>BON SECOURS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>8/16/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. City, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Wm. Cok-Brooks, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7931		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7931	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lotina, Ogreta		2. DATE AND HOUR OF DEATH AUGUST 17, 1967 5:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE MARYLAND		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		2552	
		D. STREET ADDRESS (If rural, give location) 1710 WILMINGTON AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-1-07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CURTRESS		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Jos. Lotina 1710 Wilmington St. Balto 30	
18. 199,211		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Dehydration and Malnutrition		- 5 Wx	
ANTECEDENT CAUSES		(B) DUE TO Occult Malignancy		1 Year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) 2 possible			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Hypertensive Ht Ds, Congestive Ht Failure		5-10 Year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/1/67 to 8/17/67, that (I) last saw the deceased alive on 8/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rifat Abousy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/67	
23C. PHYSICIAN'S NAME (Type) Rifat Abousy		23D. ADDRESS M.D. 1212 Light St., Balto., Md., 30			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 8/19/67		24C. NAME of CEMETERY or CREMATORY Lorraine Mausoleum	
24D. LOCATION (City, town, or county) Balto. Co., Md.		24E. (State) (Stol)			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.	

THE A. C. & S. CO. LTD. LONDON

W. & A. GILBERT

THE A. C. & S. CO. LTD.

W. & A. GILBERT

LONDON

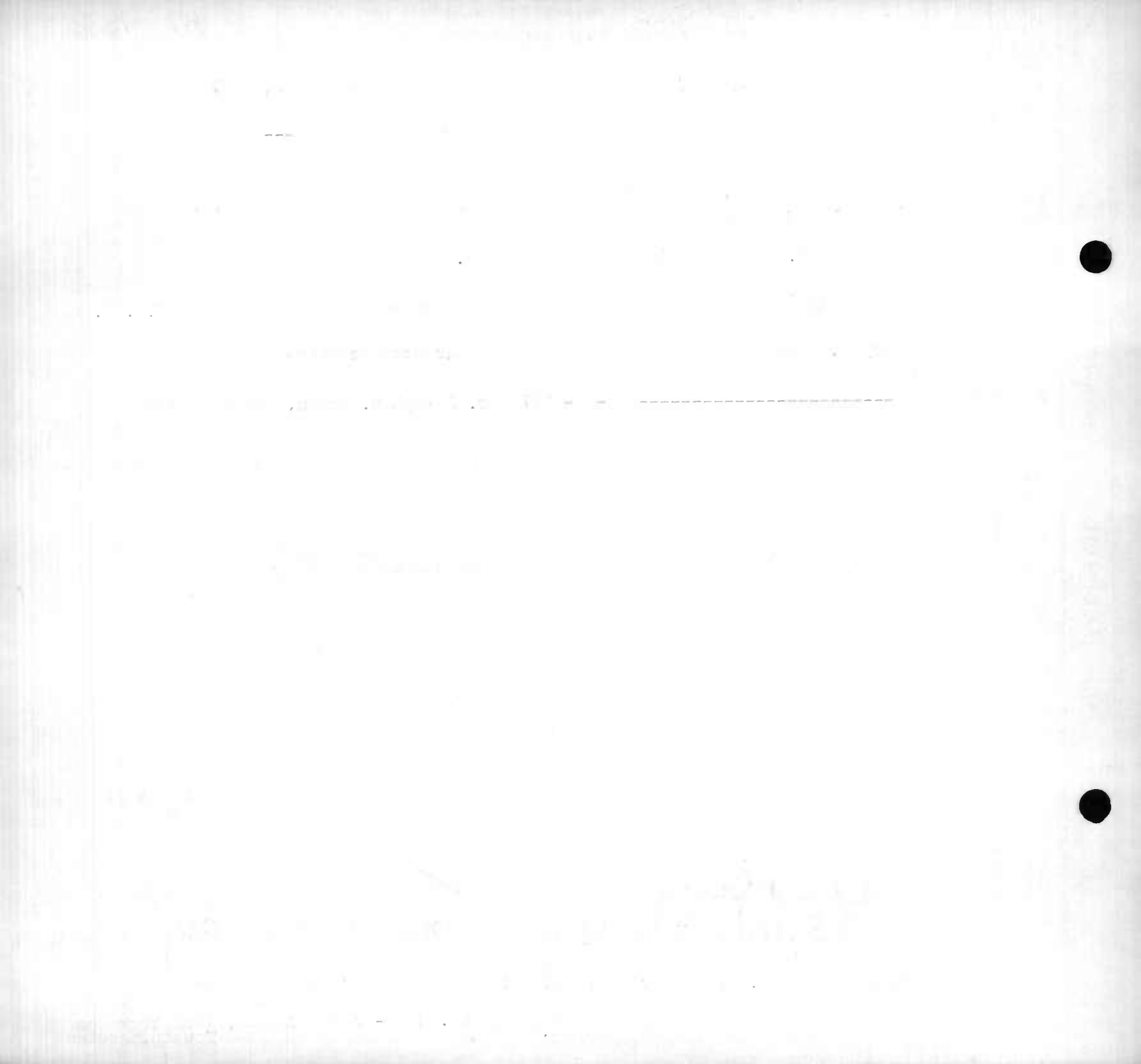
W. & A. GILBERT

THE A. C. & S. CO. LTD. LONDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7932		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7932	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LEORA ELIZABETH BOWEN		August 17, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
House in the Pines, Belvedere 2525 Belvedere Avenue		Baltimore		2900 Inglewood Avenue 21234	
5. SEX Female	6. RACE Cau.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 3, 1883	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
13. FATHER'S NAME Henry N. Kline			14. MOTHER'S MAIDEN NAME Charlotte McCleary		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-48-1277		17. INFORMANT Mr. Joseph N. Bowen, Same as # 4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Carcinoma of Breast with metastases (B) DUE TO (C) Antecedents H.D.		INTERVAL BETWEEN ONSET AND DEATH 2 years ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 67 to August 17 19 67, that (I) (we) last saw the deceased alive on August 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sylvan D. Goldberg				23B. DATE SIGNED 8/18/67	
23C. PHYSICIAN'S NAME (Type) Sylvan D. Goldberg M.D.				23D. ADDRESS Medical Arts Bldg. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 19, 67		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery	
				24D. LOCATION (City, town or county) (State) Towson, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Jm. Cook-Brooks	
				ADDRESS Towson, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67-08904 67 7933					CERTIFICATE OF DEATH					
Registered No. 67 7933										
1. NAME OF DECEASED (Type or Print) McKnight, Burnette					2. DATE AND HOUR OF DEATH August 15, 1967 4 ²⁵ A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 669 Portland St. 21230 22-02					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 5-6-67	9. AGE (In years last birthday) 10 wks	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levoris McKnight			14. MOTHER'S MAIDEN NAME Hattie White							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Congenital heart disease (Bilocular) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 13 weeks (life)
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (this hospital) attended the deceased from July 18 1967 to August 15 1967, that (I) last saw the deceased alive on Aug 15 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.										
23A. SIGNATURE Marston A. Young					23B. DATE SIGNED Aug 15, 1967		23C. PHYSICIAN'S NAME (Type)			
23D. ADDRESS					23E. M.D.					
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
Burial		8/17/67		Mt Auburn		Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS						
AUG 18 1967		Robert E. Fulmer		Charles R. Rice 661 W. Barre St.						

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67 7934 BALTIMORE CITY HEALTH DEPARTMENT

67 7934

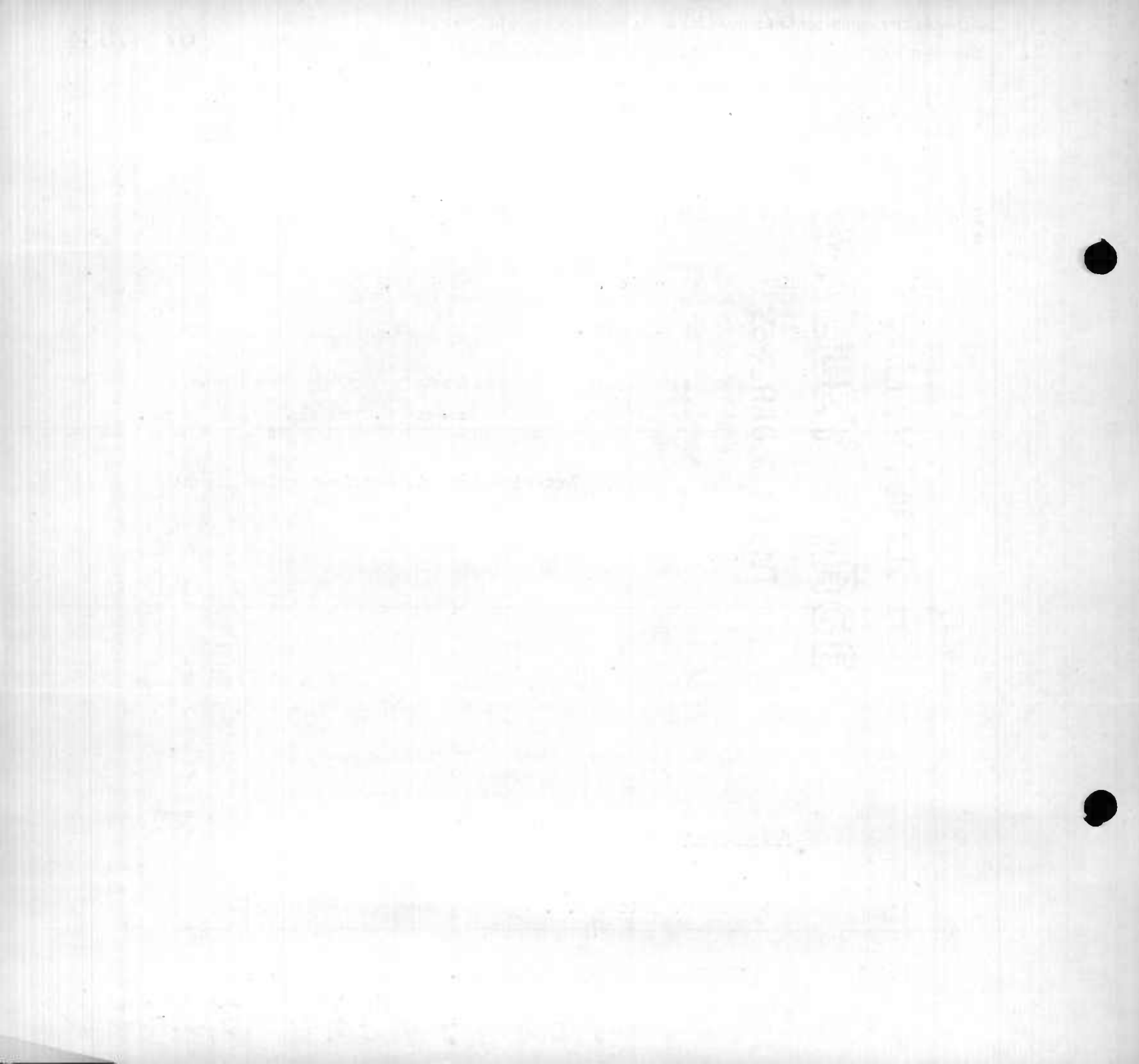
BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM B. THOMPSON		2. DATE AND HOUR PRONOUNCED DEAD August 14, 1967 6:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3343 Keswick Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married.	8. DATE OF BIRTH March 29, 1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenence (Retired)		10B. KIND OF BUSINESS OR INDUSTRY Bendix Corp.	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Elizabeth C. Thompson
		ADDRESS Same.	
18. 422.1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 8/15/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 8/17/67	23C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gardens	23D. LOCATION (City, town, or county) (State) Balto. Co
24A. DATE REC'D BY HEALTH DEPT. AUG 18 1967	24B. NAME OF REGISTRAR Robert E. Fashner	24C. FUNERAL DIRECTOR Paul C. Schenck	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7935		CERTIFICATE OF DEATH		67 7935	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		GARFIELD James Truly Oliver		8/17/67 7:35 a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
SOUTH BALTIMORE GENERAL HOSPITAL		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Sparrows Point			
		D. STREET ADDRESS (If rural, give location)			
		804 "J" Street Sparrows Point, Md.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Colored	Widower	6/29/83	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Bethlehem Steel		VA.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Benjamin Oliver			ANNIE S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-01-0396		MELVIN OLIVER 661 N. AVONDALE RD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) CHF 2-3°			
ANTECEDENT CAUSES		(B) Uremia & pulm. edema			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Severe anemia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15/67 to 8/17/67 that (we) last saw the deceased alive on 8/17/67 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Song Suck Chung				8/17/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Song Suck Chung				S.B.G.H. - 1213 Light Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/21/67		Arbutus Mem. PK	
24D. LOCATION (City, town, or county)		24E. STATE		24F. FUNERAL DIRECTOR	
Arbutus, Md.				Joseph B. Locke Jr. 1304 N. Conkey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
AUG 18 1967		Robert E. Taylor			

CH 2-2

Waters & G. L. Shaw
Waters & G. L. Shaw

Good Luck Church
Good Luck Church

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7936				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7936	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) THEODORE KING				2. DATE AND HOUR OF DEATH AUG. 17 1967 4:00 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 539 S. MONROE ST.			
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7/25/1899	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN.		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State of foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE M. KING				14. MOTHER'S MAIDEN NAME ELIZABETH GOOD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 12 4531		17. INFORMANT THEODORE KING		ADDRESS 339 S. MONROE ST.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Peritonitis secondary to perforated small bowel		INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO Diabetic Shock			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION AUG. 17/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---			
22. I certify that (I) (this hospital) attended the deceased from AUG. 16 19 67 to AUG. 17 19 67 , that (I) (we) lost saw the deceased alive on AUG. 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruben V. Luna				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUG. 17, 1967	
23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA				23D. ADDRESS FRANKLIN SQUARE HOSPITAL 1801 N. CALAVERA, BALTIMORE, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-21-67		24C. NAME of CEMETERY or CREMATORY LONDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1967		25B. NAME OF REGISTRAR P. D. 62, [Signature]		25C. FUNERAL DIRECTOR GEORGE SCHWAB FUNERAL HOME 2101 [Address]			

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B-630

67 7937

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 7937

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM R. BRADY

2. DATE AND HOUR PRONOUNCED DEAD

August 17, 1967

8:07 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2012 Greenmount Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2012 Greenmount Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept 27, 1919

9. AGE (In years
(last birthday))

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore City

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Brady

14. MOTHER'S MAIDEN NAME

Hazel Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

2

16. SOCIAL
SECURITY NO.

21840992

17. INFORMANT

Family

ADDRESS

18.

150X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of esophagus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

Aug 21/67

23C. NAME of CEMETERY or CREMATOR

Baltimore National

23D. LOCATION

Baltimore Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 18 1967

Robert E. Taylor

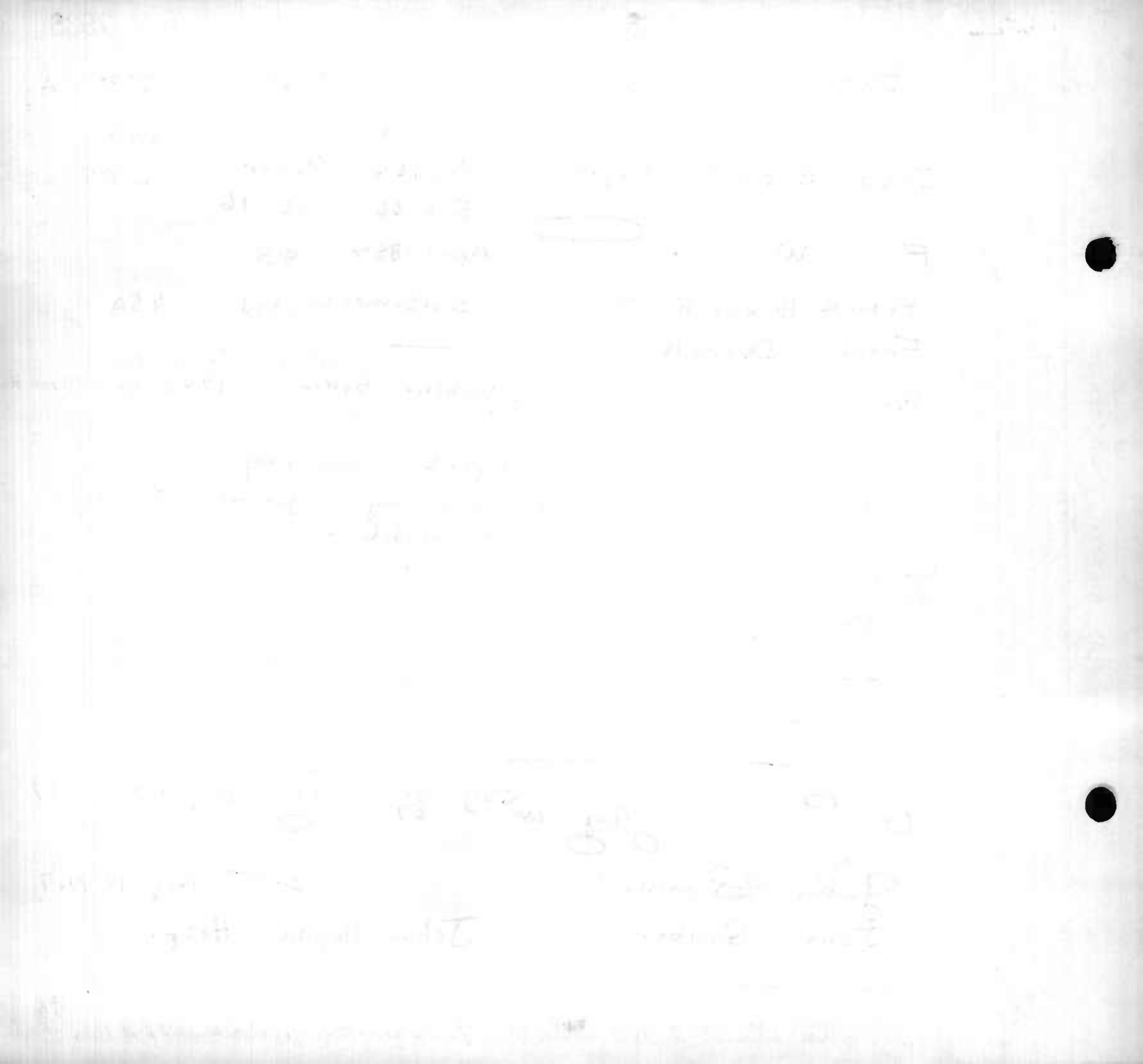
Robert E. Williams

1701 N Bond St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7938					67 7938				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Dvorak, Katie					2. DATE AND HOUR OF DEATH 8/18/67 7:05 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital					A. STATE Maryland B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Middle River 5300				
					D. STREET ADDRESS (If rural, give location) Box 66 Rt. 16				
5. SEX F	6. RACE W	7. MARRIED, <u>NEVER MARRIED</u> WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH April 1884	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housework				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Dvorak					14. MOTHER'S MAIDEN NAME — Caroline Gluth				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-58-6584		17. INFORMANT ADDRESS Webster Baker 9742 Byrd River Rd			
18. 05331 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Sepsis secondary to Gram neg. organisms					INTERVAL BETWEEN ONSET AND DEATH 3 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO to Gram neg. organisms				
					(B) DUE TO on Candida				
					(C) —				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION —			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? —			
22. I certify that (1) (this hospital) attended the deceased from July 30 1967 to Aug 18 1967 , that (1) (we) last saw the deceased alive on Aug 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John Graber					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED Aug. 18, 1967	
23C. PHYSICIAN'S NAME (Type) John Graber					23D. ADDRESS Johns Hopkins Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-1967		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967			25B. NAME OF REGISTRAR John S. Baker			25C. FUNERAL DIRECTOR ADDRESS LaSalle Funeral Home 7401 Belair Road			



E-520

67 7939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 7939

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Bessie Mae Emge
BESSIE EMGE

2. DATE AND HOUR OF DEATH

17 AUGUST 1967 1 3:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Essex (21)

D. STREET ADDRESS (If rural, give location)

344 SASSAFRAS ROAD 21221

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7-14-03

9. AGE (In years
lost birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE WILLIAMS

14. MOTHER'S MAIDEN NAME

ALICE DISNEY

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

--

16. SOCIAL
SECURITY NO.

219 16 3855

17. INFORMANT

ADDRESS

MD.

RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(A) *Hypertension*
DUE TO(B) *Congestive Heart failure*
DUE TO(C) *Uremia*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~27~~ 29 JULY 1967 to 17 AUGUST 1967,
that (I) (we) lost saw the deceased alive on 17 AUGUST 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael R. McMillan

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

17 August 1967

23C. PHYSICIAN'S
NAME (Type)

Dr. MICHAEL R. MC MILLAN

M.D.

23D. ADDRESS

BALTIMORE 21224, MD.
BALTIMORE CITY HOSPITALS, 4940 EASTERN AVE.24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/21/67

24C. NAME OF CEMETERY or CREMATORY

Belair Memorial Gardens

24D. LOCATION

Belair, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

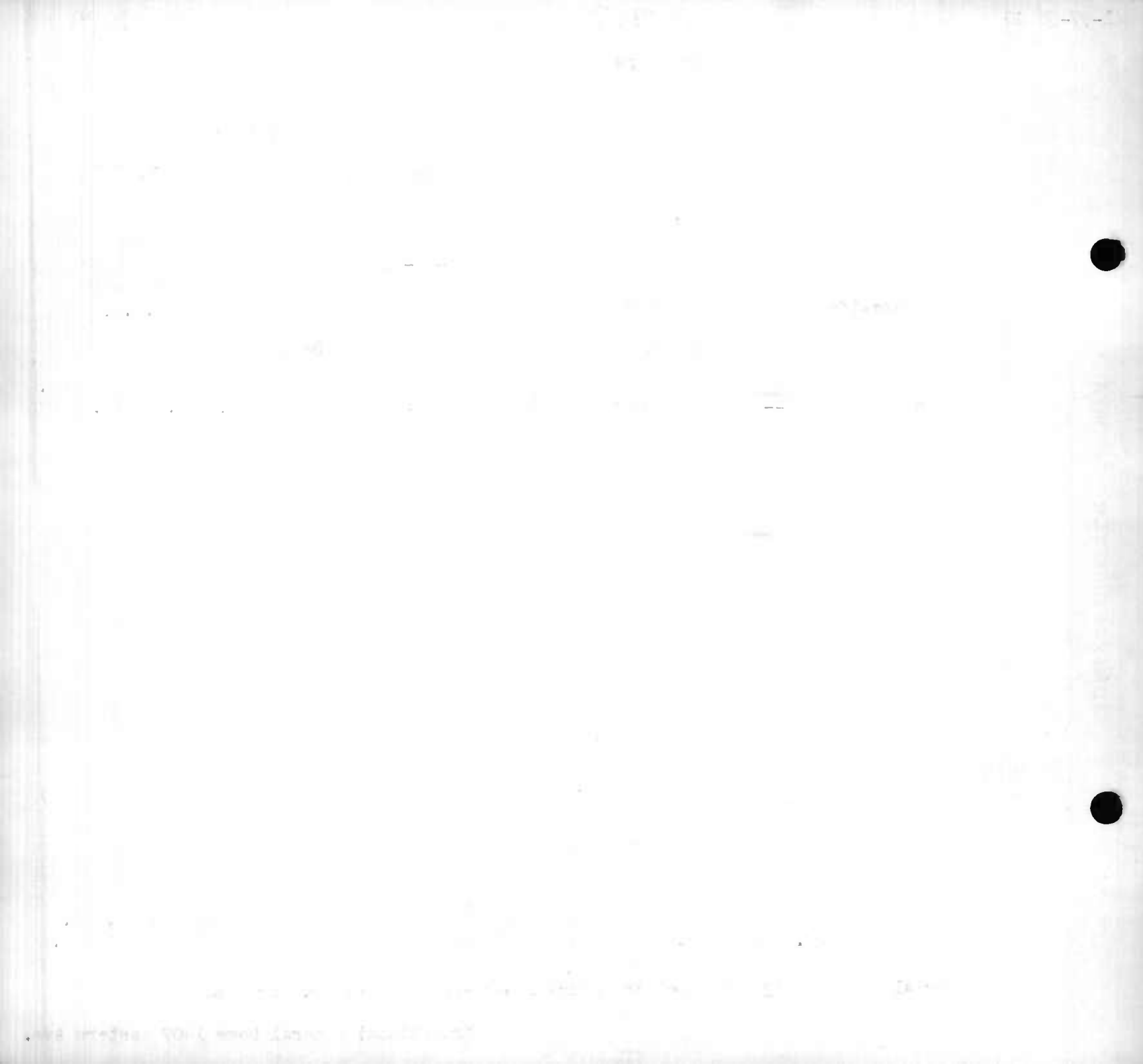
25C. FUNERAL DIRECTOR

Brazdzinski Funeral Home 1407 Eastern Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

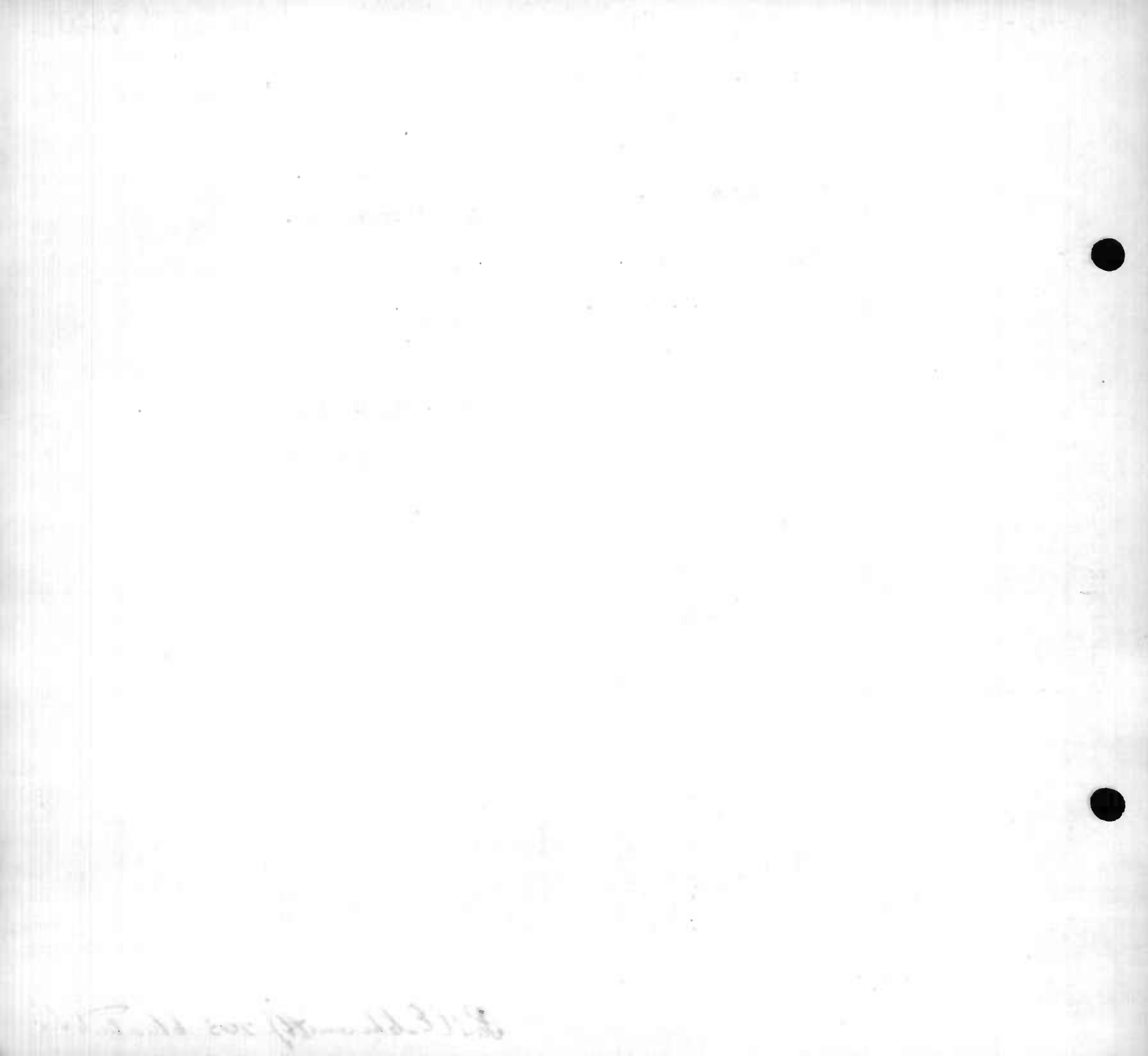
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7940	
BIRTH NO. 67 7940		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Jane L. Masenheimer			2. DATE AND HOUR OF DEATH Aug 17, 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1734 Sherwood Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore. D. STREET ADDRESS (If rural, give location) 1734 Sherwood Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed.	8. DATE OF BIRTH 6/7/1889	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesday (Retired)		10B. KIND OF BUSINESS OR INDUSTRY J.H. Filbert.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Emma E. Wolfkill 1734 Sherwood Ave.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Coronary thrombosis DUE TO (B) arteriosclerosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 minutes years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 62 to August 19 67 , that (I) was lost saw the deceased alive on August 14 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.F. Palmisano			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/18/67
23C. PHYSICIAN'S NAME (Type) J.F. PALMISANO,			23D. ADDRESS M.D. 6608 LOCH RAVEN BLVD. 21212		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial.		24B. DATE 8/21/67		24C. NAME of CEMETERY or CREMATORY Lorraine Park.	
24D. LOCATION (City, town, or county) (State) Balto.		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967			
25B. NAME OF REGISTRAR R. B. E. Faden		25C. FUNERAL DIRECTOR Paul E. Chas. 7015 Chesapeake Ave			

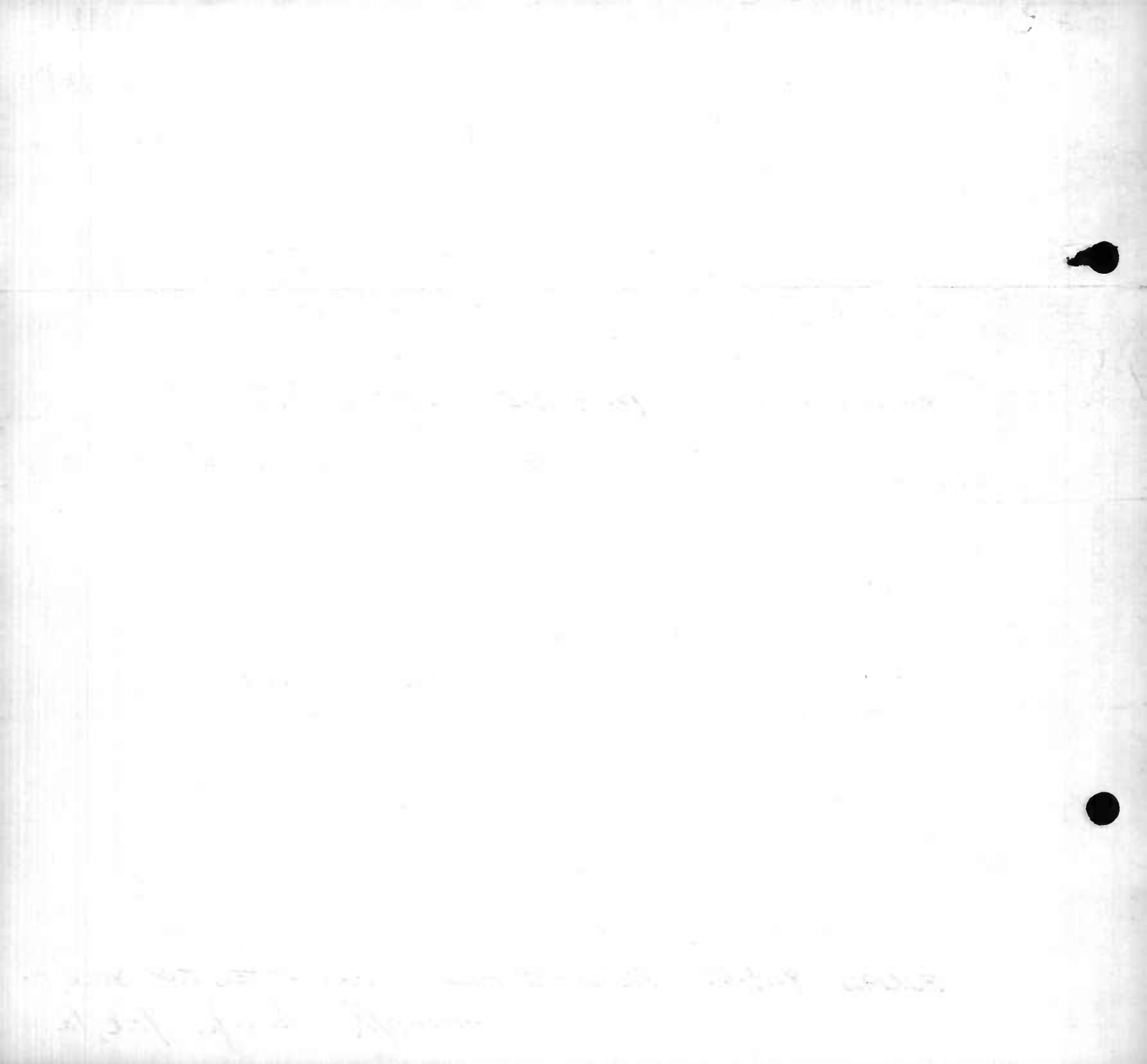


The End of the World

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 620		67 7941		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7941	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MARGUERITE BROOKS				8-16-67 10:53 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
THE JOHNS HOPKINS HOSPITAL				A. STATE PA B. COUNTY V-36			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
THAYER WARD				YORK			
				D. STREET ADDRESS (If rural, give location)			
				816 W KING ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
F	W	MARRIED	11-09-14	52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOME MAKER		—		YORK PA		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN				188-03-1385		PATIENT VIA DR. CORDES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				A. DUE TO		2 DAYS	
ANTECEDENT CAUSES				B. DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				C. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				HYPOXIA 2ND TO APNEA			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2 NONE		—		YES		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (his hospital) attended the deceased from 8-14-67 to 8-16-67, that (1) (we) last saw the deceased alive on 8-16-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Robert A Cordes M.D.				8-17-67 12:15 AM		ROBERT A. CORDES M.D.	
23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
THE JOHNS HOPKINS HOSPITAL				BURIAL		8-19-67	
				24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
				PROSPECT HILL		MANCHESTER TWP. YORK, PA.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 21 1967		Robert E. Faden		Therese L. Rodam		York, Pa.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 7942</u>	
BIRTH NO. <u>67 7942</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <u>JOHNSON, JOSEPH SOLOMON</u>		2. DATE AND HOUR OF DEATH <u>8/18/67 1:20 A.M.</u>	
(Type or Print)				M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> (If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>3804-ELM AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>08-03-97</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PAINTER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>		13. FATHER'S NAME <u>JAMES Johnson</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. FOGARTY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1ST. W. W. 705-12-3463</u>		17. INFORMANT <u>MRS EVA Johnson</u>	
18. <u>5-02-10</u>		CAUSE OF DEATH		ADDRESS <u>3804-ELM AVENUE</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>ARTERIAL Insufficiency of lower limbs.</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Bronchitis & Emphysema.</u> DUE TO			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>5-02-10</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SYMPATHETIC BLOCK SEVERE LOWER LIMB PAIN</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>08/14/67</u> 19 <u>67</u> to <u>8/18/67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/18/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Campbell</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>8/18/67</u>
23C. PHYSICIAN'S NAME (Type) <u>DERMOT CAMPBELL, DERMOT CAMPBELL</u>		23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/21/67</u>	24C. NAME of CEMETERY or CREMATORY <u>Balto National</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Austin E. Donovan - 3818 Roland Ave</u>	

The other day I was in a room

at 12:30

When I was in the room

BARBARA

My name is

My name is Barbara

My name is Barbara

My name is Barbara

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7943	
BIRTH NO. 67 7943				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TOBITHIA M. WEHNER		2. DATE AND HOUR OF DEATH August 15, 1967 3:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, 21224, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex D. STREET ADDRESS (If rural, give location) 344 Poplar Rd., # 21221.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug., 10, 1901	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Sparrows Point, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John T. Bloodsworth		
14. MOTHER'S MAIDEN NAME Minnie Mae Stokes			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT Matthew Wehner, Sr.		ADDRESS Same.	
18. 42011 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Hypertension Cerebrovascular Disease (B) DUE TO (C) Arteriosclerosis Coronary Arteries INTERVAL BETWEEN ONSET AND DEATH			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William A. Rodgers				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William A. Rodgers		23D. ADDRESS 815 Eastern Ave. Baltimore, 21221, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-67		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba.Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Charles J. Zeiler		ADDRESS 901 S. Conkling St. Balto., 21224, Md.	

Aviation Lodge

67 7944

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7944

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT J. GERST

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1967 2:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

1700 Rita Road # 21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Apr. 27, 1917

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Humble Oil Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter H. Gerst

14. MOTHER'S MAIDEN NAME

Agnes Sindel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-09-9034

17. INFORMANT

Violet M. Gerst

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4307 White Ave.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8 15 67 12:30 p.

21E. INJURY OCCURRED
WHILE AT WORK ☒ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Subject fell to ground while painting

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion on the job
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-19-67

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county) (State)

7225 Eastern Blvd. Ba. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles S. Giller

901 S. Conkling St.
Balto., 21224, Md.

1901

Jan 1st 1901

Jan 2nd 1901

Jan 3rd 1901

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Oct 7th 1901

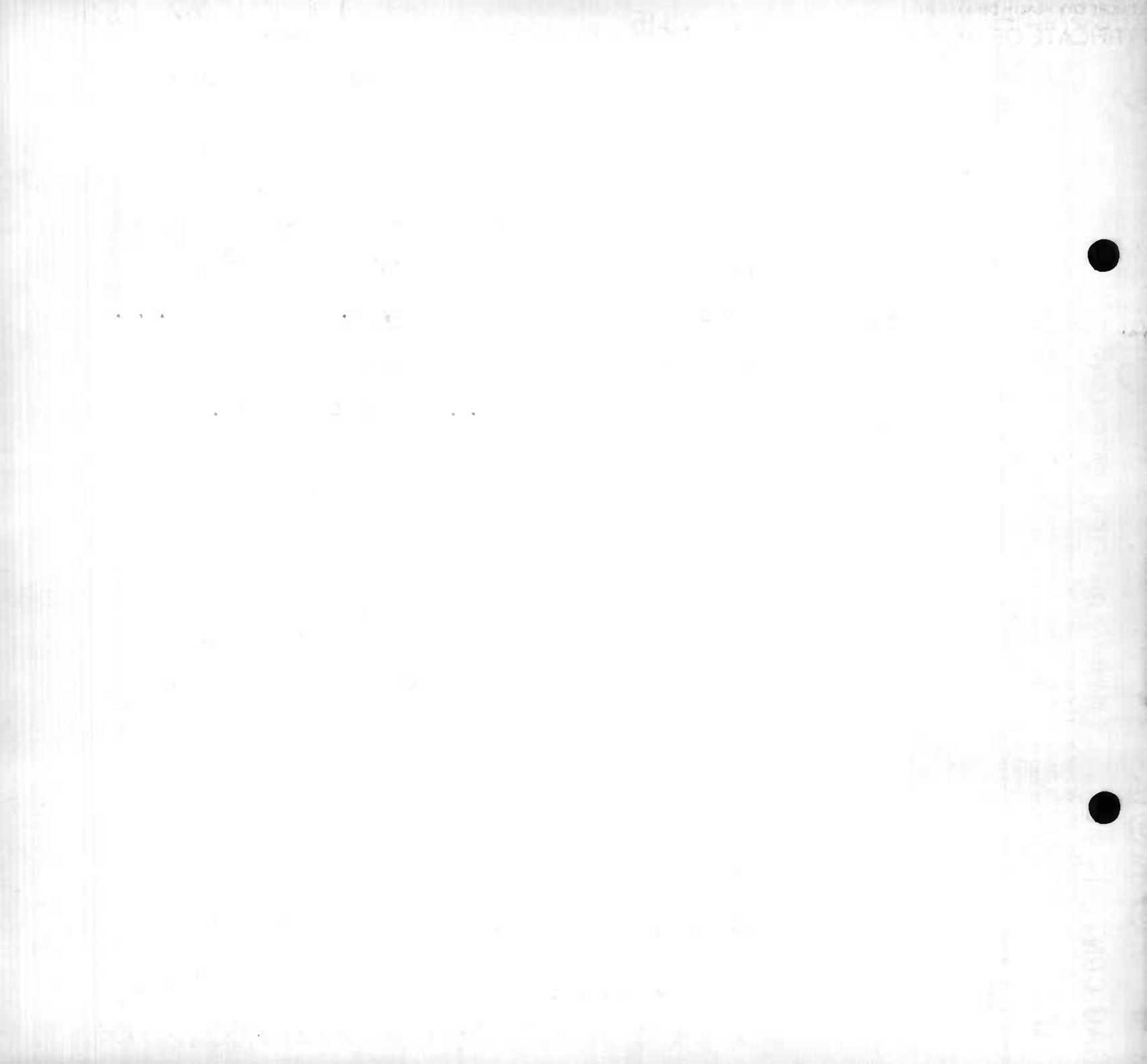
Oct 8th 1901

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO. 67 7945		67 7945		Baltimore City Health Department	
M.E. CASE NO.		67 7945		Baltimore City Health Department	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
GARRISON, MADLYN M.		8/17/67 10:40 P.M.		THE JOHNS HOPKINS HOSPITAL	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. SEX	
THE JOHNS HOPKINS HOSPITAL		MARYLAND		FEMALE	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		6. RACE	
		BALTIMORE		NEGRO	
		D. STREET ADDRESS (If rural, give location)		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
		1836 NORTH SPRING STREET		SEPARATED	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
6-16-22		45		Balto. Country Club	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY	
Virginia		U.S.A.		Head Waitress	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
WALTER BURKE		VIRGINIA HUGHES		no	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
215-24-5822		Mrs. Virginia Britt		1836 N. Spring St. 21213	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		?? Meningo-vascular Syphilis			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/16/67 to 8/17/67		19		1967	
that (I) (we) last saw the deceased alive on 8/17/67		19		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Philip Reid				August 17, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PHILIP REID		JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-20-67		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 21 1967		Robert E. Salyers		Marshall W. Jones, Jr.	
				1735 Harford Ave. 21213	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. 4

67 7946		BALTIMORE CITY HEALTH DEPARTMENT		67 7946	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
IRMA BURNS		8/20/67 125 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE BALTIMORE		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Catharian Hospital of Maryland		BALTIMORE, MARYLAND		25-43	
5. SEX f		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 5/29/14		9. AGE (In years lost birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
HOUSEWIFE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE PHUMPHREY		14. MOTHER'S MAIDEN NAME SADIE GADD		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT W.J. BURNS		ADDRESS I912 MAISEL ST. BALTIMORE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Massive Gastrointestinal Bleeding (B) Gangrene liver by Arteriosclerotic Disease (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. old cerebral vascular Accident with hemiplegia - left.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/18 1967 to 8/20 1967 that (I) (we) last saw the deceased alive on 8/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Noble		23B. DATE SIGNED 8/20/67	
23C. PHYSICIAN'S NAME (Type) J. NOBLE		23D. ADDRESS Catharian Hospital of Maryland 730 Ashburton Street Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/23/67		24C. NAME OF CEMETERY or CREMATORY HIDDEN PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE - MD.		25A. DATE RECEIVED BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR McCallister		25D. ADDRESS 306 Fort Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

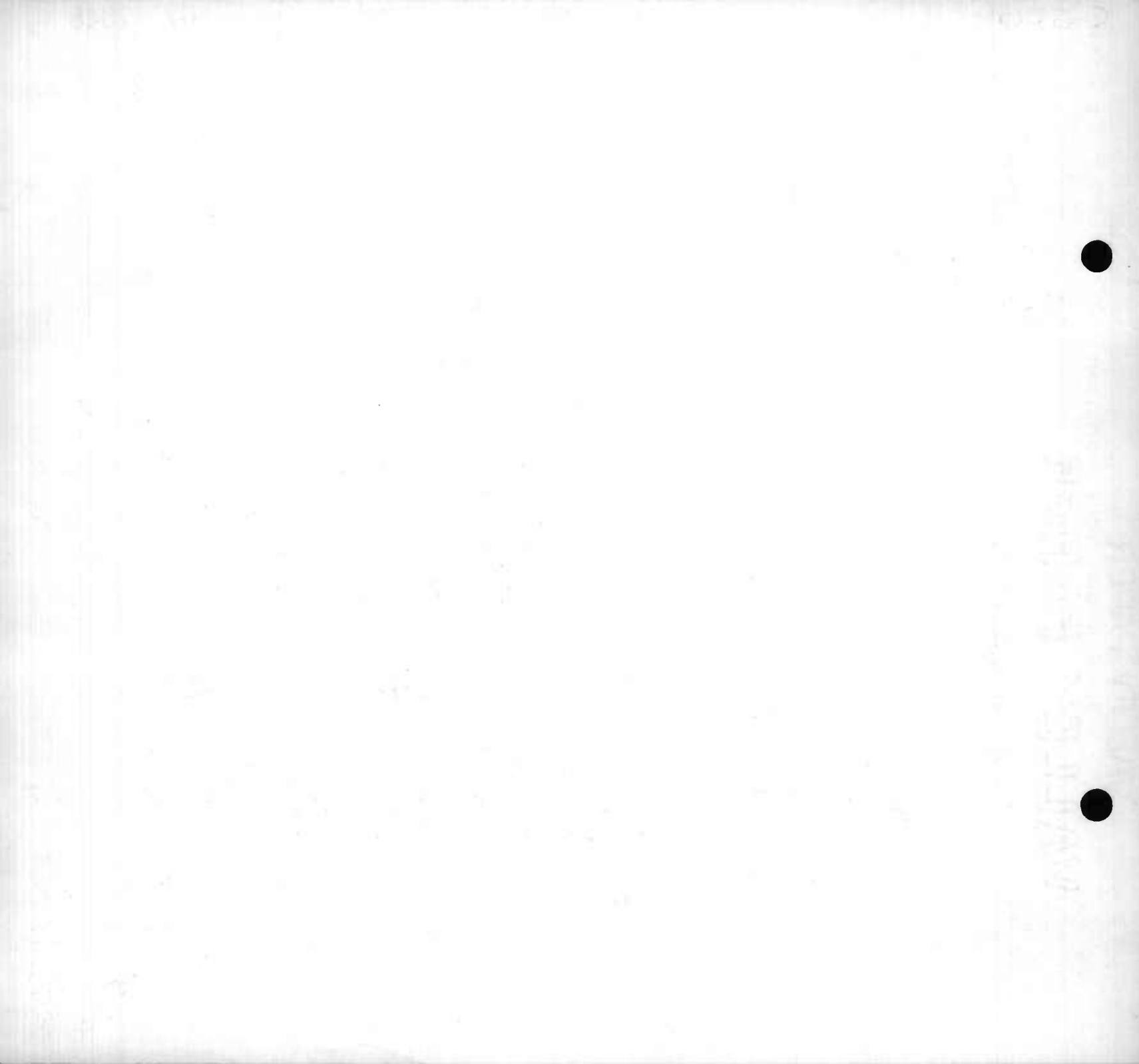
BIRTH NO.		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 7947				CERTIFICATE OF DEATH		67 7947	
1. NAME OF DECEASED (Type or Print) <u>Mary Kortesis</u>				2. DATE AND HOUR OF DEATH <u>8-16-67</u> <u>1 A. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>31 Baltimore City Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>26-11</u> D. STREET ADDRESS (If rural, give location) <u>3203 Fleet Street</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-2-02</u>	9. AGE (In years lost birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>Turkey</u>	
13. FATHER'S NAME <u>2 Lemondias</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. George Kortesis</u> <u>3203 Fleet St., Baltimore, Md.</u>		ADDRESS	
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Coronary Thrombosis</u> DUE TO (B) <u>Arterio-sclerotic C.V. Disease</u> DUE TO (C) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1hs</u>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 1965</u> to <u>August 16 1967</u> , that (I) (we) last saw the deceased alive on <u>August 11 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jason H. Gaskel</u> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>August 17, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jason H. Gaskel</u> M.D.				23D. ADDRESS <u>637 S. Conkling St., Balt., Md. 21224</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-18-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greek Orthodox Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u>		ADDRESS <u>3027 Eastern Ave., Baltimore, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 61-06080 67, 7948		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67, 7948	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BRENT Cohen		2. DATE AND HOUR OF DEATH 8/17/67 10 ⁰⁰ a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		A. STATE Md B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RANDALLSTOWN 53-00			
		D. STREET ADDRESS (If rural, give location) 9013 BRUNO Rd			
5. SEX MALE	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-2-61	9. AGE (In years last birthday) 6	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Hyman		14. MOTHER'S MAIDEN NAME EILEEN		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HYMAN COHEN	
				ADDRESS SAME	
18. 204.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) GI bleeding DUE TO intestinal obstruction & prob. leukemic infiltration (B) DUE TO acute, fulminant, stem cell Leukemia (C)		INTERVAL BETWEEN ONSET AND DEATH Terminal x 1 wk 2 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14 1967 to 8/17 1967, that (I) (we) lost saw the deceased alive on 8/17 1967 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/67	
23C. PHYSICIAN'S NAME (Type) [Signature]		23D. ADDRESS Sinai Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/67		24C. NAME of CEMETERY or CREMATORY Balto Hebrew	
				24D. LOCATION (City, town, or county) (State) Randallstown Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son Inc	
				ADDRESS Gawyer Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7949	
CERTIFICATE OF DEATH				Registered No. 67 7949	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mr. SAMUEL ZIMMERMAN		8/17/67		4:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
		A. STATE Md. 8. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
MARYLAND GENERAL HOSP		BALTIMORE 3300			
		O. STREET ADDRESS (If rural, give location)			
		14 N. HOWARD Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
M	W	WIDOWED	9/12/84	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired - UNKNOWN		UNKNOWN		Millville, N.J.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
USA		JOSEPH ZIMMERMAN			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
UNKNOWN		NO			
16. SOCIAL SECURITY NO.		17. INFORMANT			
214-01-4688		Laughter (Sarah Schrotter)			
ADDRESS		422 N. Rolling Rd			
BALTO					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CARDIOGENIC SHOCK		recent	
ANTECEDENT CAUSES		DUE TO Ruptured heart			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) MYOCARDIAL INFARCTION		2 days	
		(C) Hemopericardium			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
NONE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2 NONE				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		NONE			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 8/15 1967 to 8/17 1967, that (1) (we) last saw the deceased alive on 8/17 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frank J. Zorick M.O.				8-17-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
FRANK J. ZORICK M.D.				Maryland General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8-21-67		Mt Olivet Cemetery	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 21 1967		Robert E. Farley		Edw. Mac Nally Jr. 301 Federal Road-21228	

W-410

67 7950

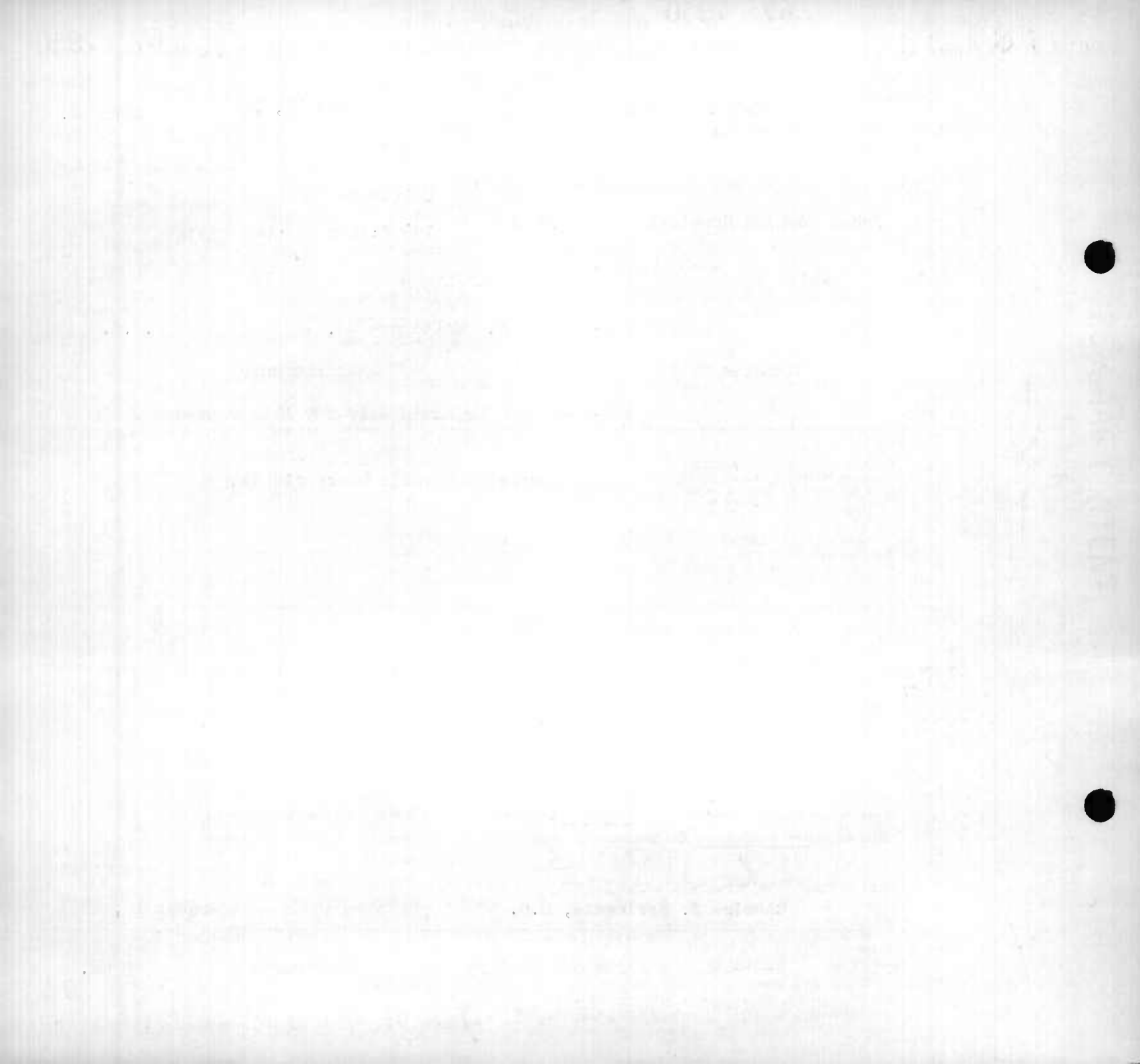
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7950

BIRTH NO.

M.E. CASE NO.

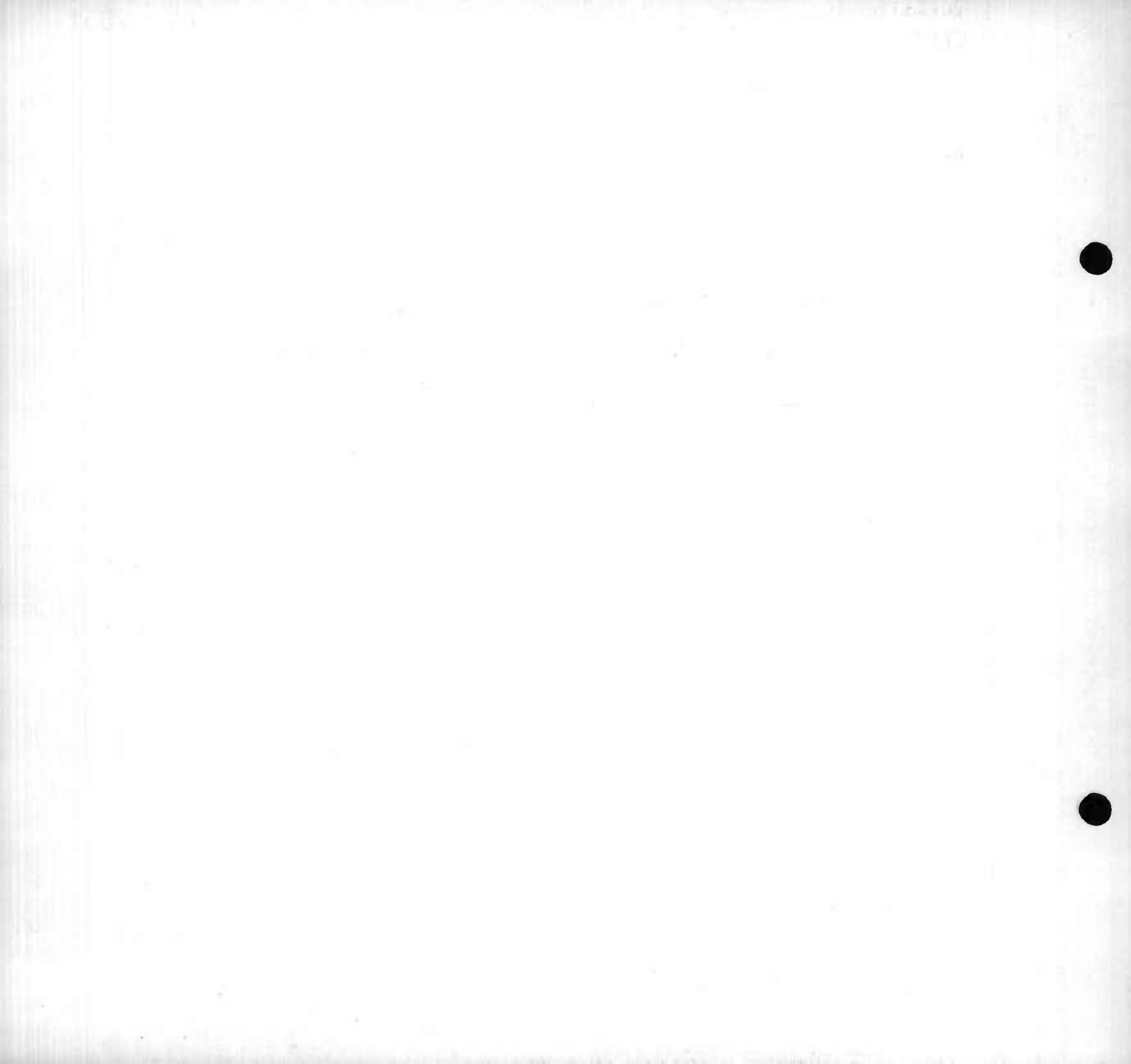
1. NAME OF DECEASED (Type or Print)		WILLIAM WOLF		2. DATE AND HOUR PRONOUNCED DEAD August 17, 1967 11:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
Johns Hopkins Hospital (DOA)		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 109 Elinor Avenue 21236			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-18-1890	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY American Refining Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Nicholas Wolf		14. MOTHER'S MAIDEN NAME Anna Blankner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-1463A		17. INFORMANT Mr Edwin Wolf 109 Elinor Avenue 21236	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 18, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-21-1967		23C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
				23D. LOCATION (City, town, or county) (State) Baltimore Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		24B. NAME OF REGISTRAR Robert E. Farkas		24C. FUNERAL DIRECTOR Lassahn Funeral Home 7461 Belair Road	
				ADDRESS 36	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 7951					67 7951				
BIRTH NO.					Registered No.				
M.E. CASE NO.					1. NAME OF DECEASED				
(Type or Print)					REED, MARY M.				
2. PLACE OF DEATH IN BALTIMORE, MARYLAND					3. DATE AND HOUR OF DEATH				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
North Charles Cor. Hoop					A. STATE Md.				
N. Charles Street					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					3019 Mathews St MATHEWS				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		Widow		March 27, 1888		79 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				--		Chicago, Ill		U.S.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Theophilus Merck					Barbara Recher				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
No					215-07-0844D		Ruth Disney (Daughter)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) CVA ; cardiac decompensation				
ANTECEDENT CAUSES					(B) Pulmonary edema ; ASCVD				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) Rheumatoid Arthritis				
II					Dr. Blum				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					AT Hospital				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Aug. 19 1967 to Aug. 19 1967.									
that (I) (we) last saw the deceased alive on Aug. 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Joseph Blum					Aug. 17, 1967				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
					1115 N. Calvert St. Balto Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)			
Burial		8/22/1967		Mount Olivet Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 21 1967		Robert E. Fairman		Eugenia K. Seitz		5209 York Rd. Balto, Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7952

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND Wm. BROWN

2. DATE AND HOUR PRONOUNCED DEAD

August 17, 1967 4:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

23 N. Broadway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

7-30-1919

9. AGE (in years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Mack Brown

14. MOTHER'S MAIDEN NAME

Sally Buffkin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lenue Buffkin, Rock Hill, S.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-20-1967

23C. NAME of CEMETERY or CREMATORY

Brown Family Cemetery

23D. LOCATION

(City, town, or county)

(State)

Chadbourn, North Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 21 1967

Charles E. Taylor, M.D.

Howard H. Hubbard, 4107 Wilkens Ave. 21229

SECRET
CONFIDENTIAL
TOP SECRET

1. The first part of the document discusses the importance of maintaining accurate records of all activities. It emphasizes that this is essential for ensuring the integrity and reliability of the information collected.

2. The second part of the document describes the various methods used to collect and analyze data. It includes a detailed explanation of the procedures followed to ensure that the data is accurate and up-to-date.

3. The third part of the document discusses the results of the data collection and analysis. It provides a summary of the findings and highlights the key areas of interest.

4. The fourth part of the document discusses the implications of the findings and provides recommendations for future research. It suggests that further studies should be conducted to explore the issues identified in the current study.

5. The fifth part of the document discusses the conclusions drawn from the study. It summarizes the main findings and provides a final assessment of the overall results.

6. The sixth part of the document discusses the limitations of the study and identifies areas for future research. It suggests that further studies should be conducted to explore the issues identified in the current study.

7. The seventh part of the document discusses the significance of the findings and provides recommendations for future research. It suggests that further studies should be conducted to explore the issues identified in the current study.

8. The eighth part of the document discusses the conclusions drawn from the study. It summarizes the main findings and provides a final assessment of the overall results.

9. The ninth part of the document discusses the limitations of the study and identifies areas for future research. It suggests that further studies should be conducted to explore the issues identified in the current study.

10. The tenth part of the document discusses the significance of the findings and provides recommendations for future research. It suggests that further studies should be conducted to explore the issues identified in the current study.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7953

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM PRICE

2. DATE AND HOUR PRONOUNCED DEAD

August 17, 1967 3:54 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2206 Ashland Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2-14-1913

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Kelly Price

14. MOTHER'S MAIDEN NAME

Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Warren- Miller Funeral Home, Lenoir, N. Caroli

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-21-1967

23C. NAME of CEMETERY or CREMATORY

Price Family Cemetery

23D. LOCATION

(City, town, or county)

(State)

Lenoir, North Carolina

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

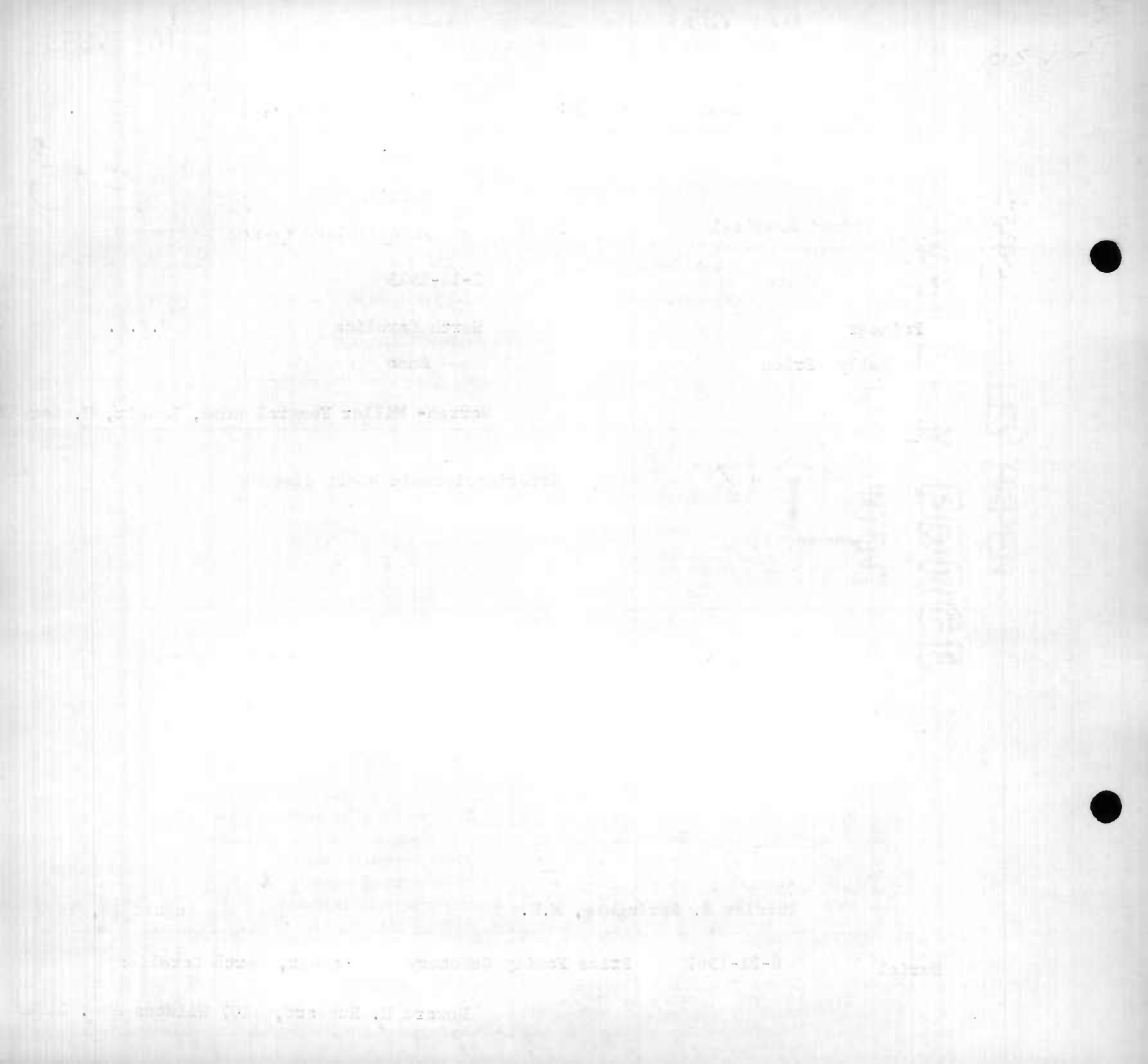
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7954		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7954	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Caroline J. Myers		
2. DATE AND HOUR OF DEATH August 18, 1967			3. A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1935 Griffiss Avenue Morrell Park, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Morrell Park C. CITY OR TOWN (If outside city limits, write RURAL and give township) 23-43 D. STREET ADDRESS (If rural, give location) 1935 Griffiss Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-11-1904	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Dietz			14. MOTHER'S MAIDEN NAME Mary Ruppel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. John L. Myers, 1935 Griffiss Ave. 21230		
18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Sudden DUE TO Anteroseptal Heart Disease 2 years Diabetes Mellitus 5 years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gangrene left big toe					
19A. DATE OF OPERATION July 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Amputation left foot		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15 19 67 to 8/18 19 67 , that (I) (we) last saw the deceased alive on 8/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr				23B. DATE SIGNED 8/18/67	
23C. PHYSICIAN'S NAME (Type) Dr. John P. Urlock, Jr		23D. ADDRESS 1227 Washington Blvd., Balto., Md. 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-21-67	24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7955	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 7955</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) MORRIS FRIEDMAN</p> </div> <div> <p>2. DATE AND HOUR OF DEATH August 17, 1967, 8:05 a.m.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale Aged Home</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) LEVINDALE HEBREW HOME & INFIRMARY, Baltimore 21215</p>		
<p>5. SEX Male</p>	<p>6. RACE White</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed</p>	<p>8. DATE OF BIRTH 1915</p>	<p>9. AGE (In years last birthday) 88</p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Clothing</p>	<p>11. BIRTHPLACE (State or foreign country) Russia</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>
<p>13. FATHER'S NAME Chaim Friedman</p>			<p>14. MOTHER'S MAIDEN NAME Unknown</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 215-01-8168</p>	<p>17. INFORMANT ADDRESS Milton Friedman- 5400 Fairlawn Ave.</p>		
<p>18. CAUSE OF DEATH</p> <p>#22.1 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>ASCVD</p>			<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>years</p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (this hospital) attended the deceased from 8/9 19 61 to 8/17 19 67, that (we) last saw the deceased alive on 8/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Susan Legat</p>				<p>23B. DATE SIGNED 8/17/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) Susan Legat</p>		<p>23D. ADDRESS Levindale</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>	<p>24B. DATE 8/18/67</p>	<p>24C. NAME OF CEMETERY or CREMATORY Workmens Circle</p>	<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>		
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967</p>		<p>25B. NAME OF REGISTRAR R. B. E. Taylor</p>		<p>25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. 6010 Reist Rd.</p>	

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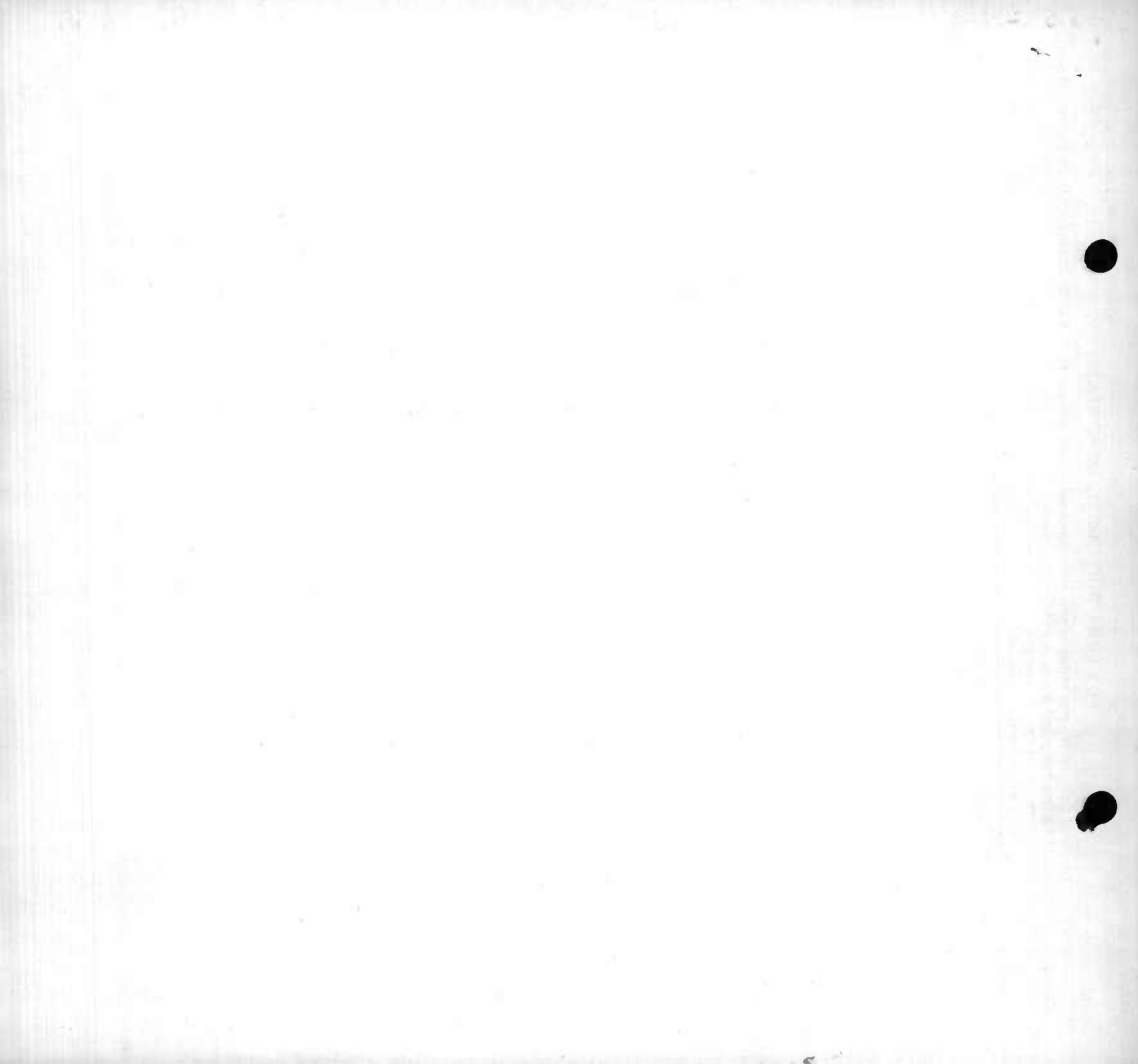
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7956				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7956	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>SAMUEL A. SIMONS</i>				2. DATE AND HOUR OF DEATH <i>8/16/67</i> <i>8¹⁶ P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland Gen Hosp</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>15-11</i>			
				D. STREET ADDRESS (If rural, give location) <i>3620 Wabash Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i> <i>Single</i>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <i>68</i>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Textile</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oscar Simons</i>				14. MOTHER'S MAIDEN NAME <i>Baila ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>WW & 1 Army</i>		16. SOCIAL SECURITY NO. <i>215-03-9908</i>		17. INFORMANT <i>Sidney R. Simons--6800 Liberty Rd.</i>			
18. <i>4201 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Coronary Occlusion</i> DUE TO (B) <i>arteriosclerotic cardiovascular disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>died suddenly</i> <i>May 1 1963</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>May 1 1963</i> to <i>Aug 16 1967</i> , that (I) (we) last saw the deceased alive on <i>July 27 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Milton B. Kress</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Aug 17 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>MILTON B. KRESS</i>				23D. ADDRESS <i>2120 Medical Arts Bldg Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/18/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Ohel Yabov Cong.</i>		24D. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SON LEVINSON & BROS INC. 6010 Reist Rd.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>8517957</u>	
BIRTH NO. <u>67 7957</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MYRTLE Mc NEILL (nee WARDELL)</u>		2. DATE AND HOUR OF DEATH <u>8-18-67 11:55 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Center</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>8-0</u> D. STREET ADDRESS (If rural, give location) <u>1708 E CHASE ST</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never MARRIED</u>	8. DATE OF BIRTH <u>11-27-97</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>AL Fred Boardly</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records Bolton Hill</u>	
18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <u>7/27</u> 19 <u>67</u> to <u>8/18</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALLAN H. MACHT</u> M.D.				23B. DATE SIGNED <u>8/19/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT</u> M.D.		23D. ADDRESS <u>2 EAST READ ST 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 22/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cem</u>	
24D. LOCATION <u>Ad. County Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Frank E. Gluckman 11297 N. Calhoun</u>			

JONES, JESSIE
825774

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7958		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7958	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Tessie Jones		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				8/17/67		8:10 A M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
				D. STREET ADDRESS (If rural, give location)		1517 BIDDLE STREET	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
MALE		NEGRO		MARRIED		9-21-29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
unemployed steel worker				Littleton N. Carolina			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Adolphus Jones				Josephine Baker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.				246-38-1026		Florence Jones 15178 Biddle St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
165X1				Melastolic Ca of Lung			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 8/12 1967 to 8/17 1967, that (we) last saw the deceased alive on 8/17 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Murray A. Katz						8/17/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MURRAY A. KATZ				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		Aug 19/67				Littleton N. Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 21 1967		Robert E. Taylor		John T. Edwards 1129 N. Carolina St			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <i>Charles Co., Md. 67 7959</i>					REGISTERED NO. <i>67 7959</i>				
M.E. CASE NO.					1. NAME OF DECEASED				
(Type or Print)					JAMES V. KEYS				
2. DATE AND HOUR OF DEATH					8-17-67 1.30 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
INSTITUTION					MARYLAND, CHARLES				
THE JOHNS HOPKINS HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					NAJEMAY <i>NANJEMAY</i> 58-00				
D. STREET ADDRESS (If rural, give location)									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		NEGRO		NEVER MARRIED		7-14-67		--	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
								1 3	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN W. KEYS					LILLIAN CARROLL				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO			2 days	
ANTECEDENT CAUSES					(B) DUE TO			2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO			1 month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2					YES		NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 8/14 1967 to 8/17 1967, that (I) (we) last saw the deceased alive on 8/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
A. Abraham								8/17/67	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
A. ABRAHAM					Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
CREMATION		8-17-67		JOHNS HOPKINS HOSPITAL			BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
AUG 21 1967		Robert E. Farley			HOSPITAL DISPOSAL				

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 April 12 1842 1842

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 64-23773		67 7960		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7960	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MC GUIRE, GERALD DONALD JR			
2. DATE AND HOUR OF DEATH AUGUST 15, 1967 11:10 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL				A. STATE MARYLAND			
				B. COUNTY BALTIMORE			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 4654 MARBLE HALL ROAD			
5. SEX M	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9-2-64	9. AGE (In years last birthday) 2 years	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GERALD D. MC GUIRE SR.				14. MOTHER'S MAIDEN NAME BERNADETTE SHELTON SAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Gerald McGuire Sr. 4654 Marble Hall			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Acute confluent bronchopneumonia (A) DUE TO RESPIRATORY ARREST pleural effusion bilateral LARYNGOTRACHEOBRONCHITIS (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days <i>McGuire</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8-7-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED APNEA		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUG. 7, 1967 to AUG. 15, 1967 , that (I) (we) last saw the deceased alive on AUG. 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
23A. SIGNATURE Markene Maribor				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-15-67	
23C. PHYSICIAN'S NAME (Type) GEDEON BRETZ				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/67		24C. NAME of CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Rebecca Taylor		25C. FUNERAL DIRECTOR Wm C. March		ADDRESS 928 E. North Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7961				Baltimore City Health Department		Registered No. 65 85 32	
M.E. CASE NO. 11-610				M. 67 7961			
1. NAME OF DECEASED (Type or Print) <i>Minnie Harvey</i>				2. DATE AND HOUR OF DEATH 8-18-67 3:25 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2206 GREENMOUNT AVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 1-24-07	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM THORNTON				14. MOTHER'S MAIDEN NAME IRENE THORNTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Ferrar 2206 Greenmount Ave			
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) ? Pulmonary embolus DUE TO (B) HASCUP DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/14 19 67 to 8/17 19 67, that (I) (we) last saw the deceased alive on 8/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kenneth L. Brigham</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-18-67	
23C. PHYSICIAN'S NAME (Type) KENNETH BRIGHAM		23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem		24D. LOCATION (City, town, or county) (State) Anne Arundel City Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. C. Match		ADDRESS 928 E North Ave	

FUNERAL DIRECTOR: IMPORTANT

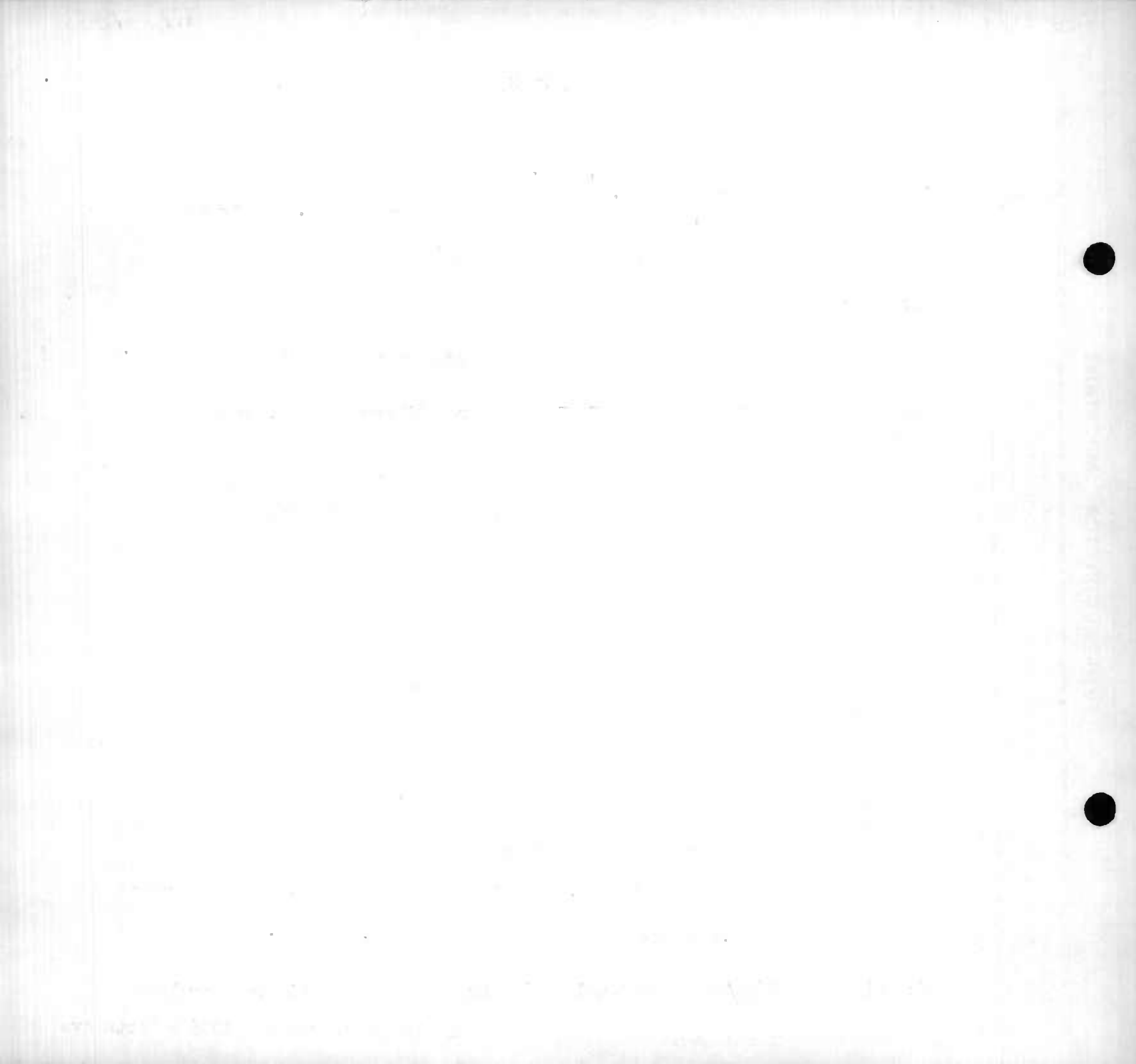
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7962	
BIRTH NO. 67 7962		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOYNER MABEL		2. DATE AND HOUR OF DEATH 8-17-1967 12 15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) Lutheran Hospital of Maryland		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2631 Harlem Ave			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 4/19/14	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Mack Lethan		14. MOTHER'S MAIDEN NAME Addie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Emmitt Joyner, same ADDRESS	
18. 322X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Pulmonary edema (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ✓					
19A. DATE OF OPERATION ✓		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ✓		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ✓		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ✓		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-8-1967 to 8-17-1967 , that (I) (we) last saw the deceased alive on 8-17-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nguyen Thi Oanh M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-17-67	
23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH		23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/20/67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) A A County Md		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7963	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 7963 67 7963 </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) George Griffin (Frank)			2. DATE AND HOUR OF DEATH August 18, 1967 3:50 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 532 Johanna St. JOHANNSEN ST		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 4/6/93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Ethel Gibson 532 Johanna St.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W I		16. SOCIAL SECURITY NO. 218-01-1308	17. INFORMANT ADDRESS Mrs Gibson , same		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) Status Epilepticus DUE TO Cerebrovascular Accident (B) DUE TO (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 12, 1967 19 to August 17 19 67 that (I) (we) last saw the deceased alive on August 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gregorio S. Tengco M.D.				23B. DATE SIGNED 8-18-67	
23C. PHYSICIAN'S NAME (Type) Gregorio S. Tengco M.D.				23D. ADDRESS 1514 Division St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/67		24C. NAME of CEMETERY or CREMATORY National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Philip E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	



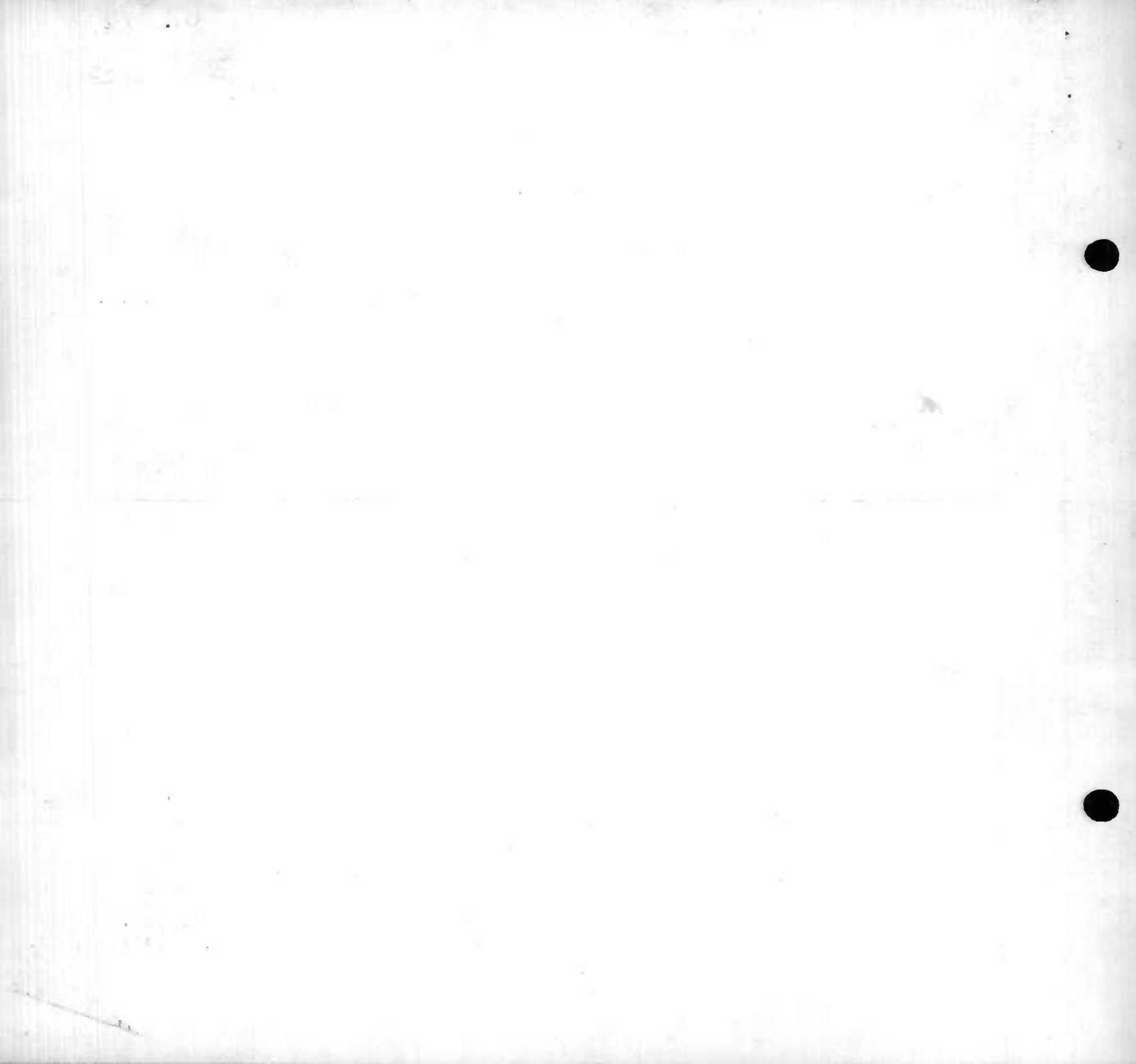
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7964	
BIRTH NO. 67 7964				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELSIE TIBBS		2. DATE AND HOUR OF DEATH 8/19/67 1:30 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 LINCOLN NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1305 D. STREET ADDRESS (If rural, give location) 864 LENNOX ST			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH SEPT 28, 1899	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia Pa	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Martha			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Reva Strom, same	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH CARCINOMA OF ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/19/67 19 to 8/19/67 19 that (I) (we) last saw the deceased alive on 8/19/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/19/67	
23C. PHYSICIAN'S NAME (Type) HOLLIS FENNARINE		23D. ADDRESS 5519 KENNISON AV BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/23/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION A A County Md		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7965	
BIRTH NO. 67 7965		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Waters Emma</u>		2. DATE AND HOUR OF DEATH <u>Aug 18 1967</u> <u>1 425 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore City</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore, Inc.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2240 Pennsylvania Ave #17</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6/12/04</u>	9. AGE (In years lost birthday) <u>63</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frank Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Susan Cook</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical Record</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Pancreas</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension Cardiovascular disease</u> <u>Hiatus hernia, esophagitis, alcoholism</u>					
19A. DATE OF OPERATION <u>7/11/67</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Transverse colectomy</u> <u>Exp Rep: drainage above</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/11/67</u> 19 <u>67</u> to <u>8/18</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Paul Barry Alperstein</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/18/67</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <u>Sinai Hospital of Baltimore, Inc.</u> <u>Belvedere at Greenspring, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8-22-67</u>	24C. NAME of CEMETERY or CREMATORY <u>Balto. Nat'l. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1967</u>		25B. NAME OF REGISTRAR <u>Paul E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Keyson Funeral Home</u>	
				ADDRESS <u>1348 Calhoun St.</u>	



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L-200

67 7966 BALTIMORE CITY HEALTH DEPARTMENT

67 7966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LAURA LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

August 18, 1967 2:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1215 Parrish Street-Balto., Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1215 Parrish Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

6-18-06

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Asbury Milligan

14. MOTHER'S MAIDEN NAME

Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edward Brown 2807 Edgcombe Circle

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-23-67

23C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l. Cem.

23D. LOCATION

(City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 21 1967

R. S. Fisher

Kelson Funeral Home 1348 Calhoun St.

WALLER PAPER

WALLER'S PAPER

WALLER'S PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 7967		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7967	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <i>Nancy Bell Palmer</i>			2. DATE AND HOUR OF DEATH <i>8/17/67 1200 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i> <i>Baltimore, Maryland</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1122 Laurens St.</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH <i>8/12/11</i>	9. AGE (In years lost birthday) <i>56</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Joseph Green</i>		
14. MOTHER'S MAIDEN NAME <i>Ida Bets</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>-</i>			17. INFORMANT <i>Lottie Palmer</i>		
18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Coronary Heart Failure</i> DUE TO (B) <i>Hypertensive Cardio-vascular Dis.</i> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/16/67</i> to <i>8/17/67</i> 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>8/17</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles Jordan</i>				23B. DATE SIGNED <i>8/17/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>University Hospital</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-21-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 21 1967</i>			
25B. NAME OF REGISTRAR <i>R. B. Fisher</i>		25C. FUNERAL DIRECTOR <i>Kelson Funeral Home</i>		25D. ADDRESS <i>1348 Calhoun St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 2767-67 7968	
BIRTH NO. 67 7968		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Alberta Silverta Carter		2. DATE AND HOUR OF DEATH August 18, 1967 9:00 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Provident Hospital 1514 Division Street Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED Single	
8. DATE OF BIRTH 5-24-32		9. AGE (In years lost birthday) 35		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia Crutchfield		ADDRESS 2138 McCulloh St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pyrotosis		CAUSE OF DEATH (A) Pyrotosis (B) Cellulitis of nose (C) Tea of epidemic		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1, 1967 19 to August 18, 1967 19, that (I) (we) last saw the deceased alive on August 18, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. C. Laredo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-18-67	
23C. PHYSICIAN'S NAME (Type) Dr. C. Laredo		23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-23-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Dr. C. Laredo		25C. FUNERAL DIRECTOR Keyson Funeral Home	
		ADDRESS 1348 Calhoun St.			

V.S. 153

8-22-67

M.H.

1
D-625

67 7969

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7969

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROSETTA DARGON

2. DATE AND HOUR PRONOUNCED DEAD

August 18, 1967 11:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2611 Spellman Road

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

5-25-49

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vernon Dargan

14. MOTHER'S MAIDEN NAME

Gladys Wilkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Gladys Dargan 2622 Spellman Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Paca St. North of Fayette St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8 18 67 10:10 p.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subject, passenger in auto into

parked car

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8-23-67

23C. NAME of CEMETERY or CREMATORY

Arbutus em. Pk.

23D. LOCATION

(City, town, or county)

Arbutus

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

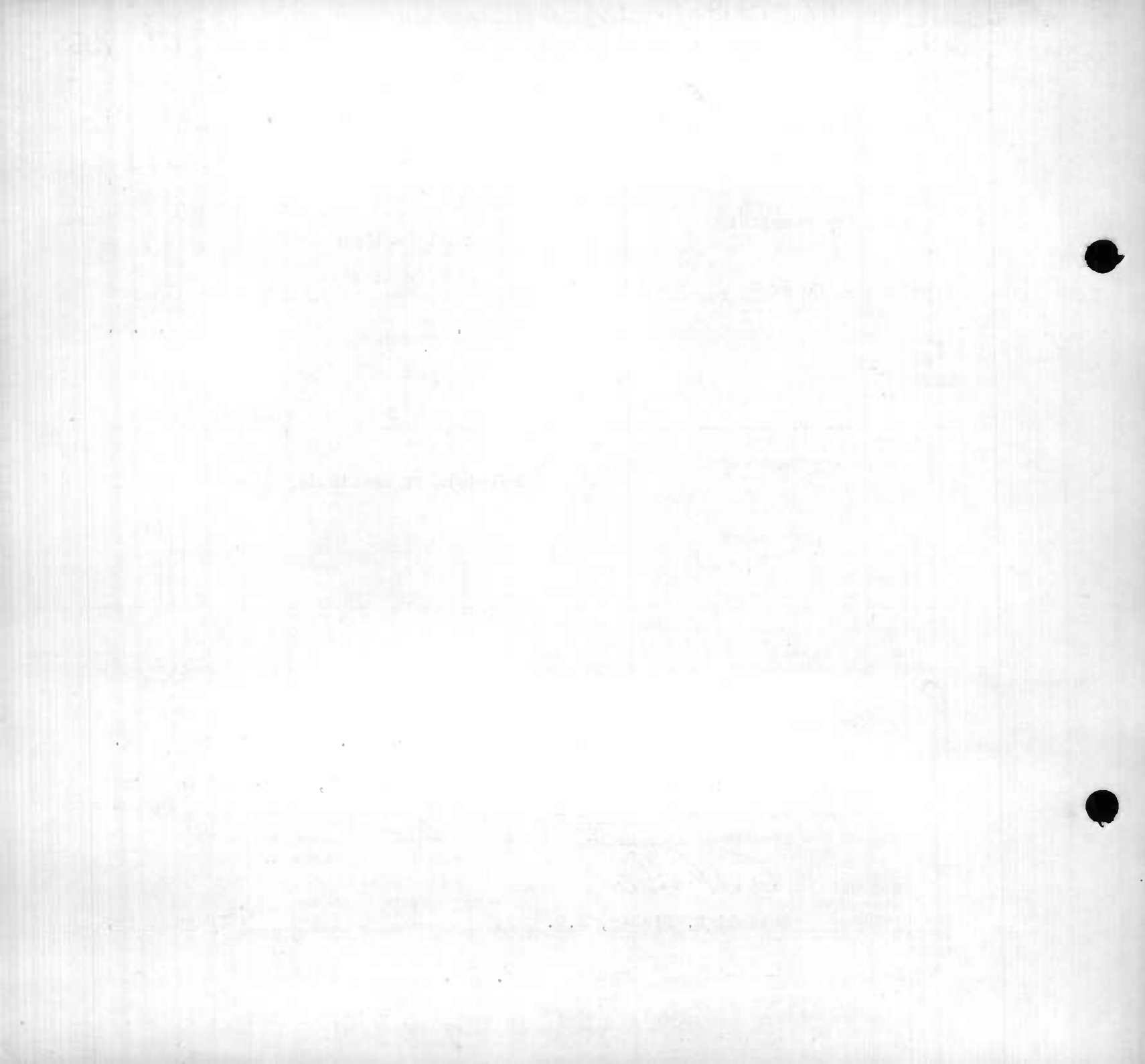
24C. FUNERAL DIRECTOR

ADDRESS

AUG 21 1967

R. E. Fisher

Kelson Funeral Home 1348 Calhoun St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7970		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 7970	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Cromer, Hillard</i>		2. DATE AND HOUR OF DEATH <i>8/18/67 7:20 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>20-01</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>117 N. Payson St.</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>March UNKNOWN</i>	9. AGE (In years last birthday) <i>53</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RESTAURANT</i>		11. BIRTHPLACE (State or foreign country) <i>NEW BERRY S. Carolina</i>	
13. FATHER'S NAME <i>James Cromer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Scott</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>252-10-8677</i>		17. INFORMANT <i>Patient's Chart</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Confluent bronchopneumonia, lower lobes</i>		CAUSE OF DEATH <i>Fatty metamorphosis of liver + delirium tremens</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>8/8/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>coma</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/6/67</i> 19 <i>67</i> to <i>8/18</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>8/18</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>7:20 A.M.</i>					
23A. SIGNATURE <i>[Signature]</i> M.D.				23B. DATE SIGNED <i>8/18/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>KYE SOON KIM</i> M.D.				23D. ADDRESS <i>BON SECOURS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/22/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT CALVARY</i>	
24D. LOCATION (City, town, or county) (State) <i>A.A. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 21 1967</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>	
25C. FUNERAL DIRECTOR <i>[Signature]</i>		25D. ADDRESS <i>636 N. Gilmory</i>			

Dr. J. H. ...
...
...

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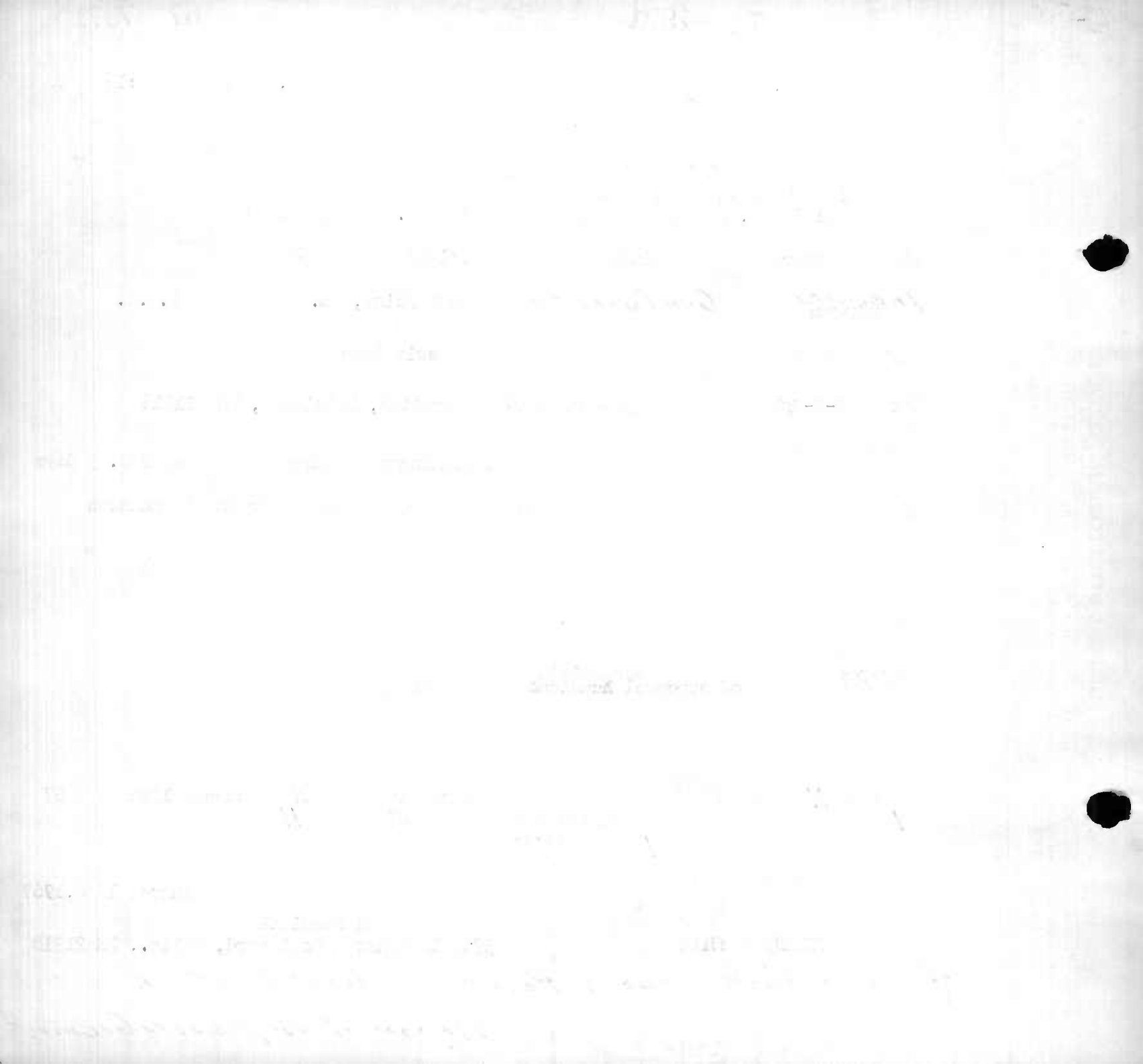
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7971	
BIRTH NO.		67 7971		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LOUDEN, ROBERT FOSTER		2. DATE AND HOUR OF DEATH August 18, 1967 8:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1014 N. Fulton Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6/1/09	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Gen Contractor		11. BIRTHPLACE (State or foreign country) West Point, Va.	
13. FATHER'S NAME George Loudon		14. MOTHER'S MAIDEN NAME Bessie Page		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9-9-42		16. SOCIAL SECURITY NO. 224-01-1591		17. INFORMANT ADDRESS VA Hospital, Baltimore, Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary failure		CAUSE OF DEATH (A) DUE TO Infarct temporal lobe of brain (B) DUE TO unknown (C) _____		INTERVAL BETWEEN ONSET AND DEATH approx. 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/7/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED possibility of subdural hematoma		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 11 (this hospital) attended the deceased from August 1st 19 67 to August 18th 19 67 , that 11 (we) lost saw the deceased alive on August 18th 19 67 and that in 11 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) 11/11/11 view the body after death.					
23A. SIGNATURE V.B. Mulay				23B. DATE SIGNED August 18th, 1967	
23C. PHYSICIAN'S NAME (Type) VISHNU B MULAY		23D. ADDRESS VA Hospital 3900 Loch Raven Boulevard, Balto., Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8/18/67		24C. NAME OF CEMETERY or CREMATORY WEST POINT	
24D. LOCATION WEST POINT VA		24E. DATE REC'D BY HEALTH DEPT. AUG 21 1967			
25A. NAME OF REGISTRAR Robert E. Finkbeiner		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR James P. Hayes	
25D. ADDRESS 638 N. Gilman		25E. ADDRESS 638 N. Gilman			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7972	
67 7972					
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>NATHANIEL WEEKS</u>	
2. DATE AND HOUR OF DEATH <u>8-13-1967</u> <u>12¹⁵ P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nursing Home</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>1104</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>309 W. Preston St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>6/3/1875</u>	9. AGE (In years last birthday) <u>92</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-306738</u>		17. INFORMANT <u>Christ</u>	
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Generalized Arterioscl.</u> DUE TO (B) <u>Chr. Brain Syndrome</u> DUE TO (C) <u>Cerebrovascular Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/15/1965</u> to <u>8/13/1967</u> , that (I) (we) last saw the deceased alive on <u>8/12/1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E E Holt</u>				23B. DATE SIGNED <u>8/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>E E Holt</u>		23D. ADDRESS M.D. <u>3715 Liberty Height Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Green Mount</u>	
24D. LOCATION <u>Bklt.</u>		24E. (City, town, or county) (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Samuel R. Givens</u>	
25D. ADDRESS <u>1712 W. North Ave</u>					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TOUSSAINT M. GREEN

2. DATE AND HOUR PRONOUNCED DEAD

August 18, 1967 8:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

233 S. Hilton Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

233 S. Hilton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-5-1908

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY
Glass Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Louis F. Greene

14. MOTHER'S MAIDEN NAME

Mary A. Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-09-6532

17. INFORMANT

ADDRESS

Vivian H. Greene - 233 S. Hilton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-23-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Finkbeiner, M.D.

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7974	
BIRTH NO. 67 7974		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SAVAGE NATHANIEL		2. DATE AND HOUR OF DEATH 8-19-67 1 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-09	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital of Maryland		D. STREET ADDRESS (If rural, give location) 3924 Duvall Avenue			
5. SEX Male	6. RACE Coloured	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-21-1916	9. AGE (In years lost birthday) 50 years	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jesse Savage			14. MOTHER'S MAIDEN NAME Alice Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Emma Savage - 3924 Duvall Ave.	
18. 33611 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Amyotrophic lateral Sclerosis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH few minutes 2 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-12-1967 to 8-19-1967 , that (I) (we) last saw the deceased alive on 8-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi				23B. DATE SIGNED 8-19-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI				23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton St. Baltimore MD 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967			
25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR Charles R. Law			
25D. ADDRESS 802 Madison Ave.					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7975				BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No. 67 7975	
1. NAME OF DECEASED (Type or Print) BLANCHE E. CARROLL				2. DATE AND HOUR OF DEATH 8-18-67 7:15AM				M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Md.				B. COUNTY	
5. SEX Female				6. RACE Negro				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Known				10B. KIND OF BUSINESS OR INDUSTRY Housewife				11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albie Carroll				14. MOTHER'S MAIDEN NAME Sarah Carroll				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Records-BCM 4940 Eastern Ave. Balto., Md. 21224	
18. 14191				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Carcinoma of tongue -				?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Pneumonia				↓	
				(C) Pulmonary Embolism				✓ as above	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION Aug 4-67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of tongue				20A. AUTOPSY? (Yes or No) Yes; rural	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---				21C. WHERE DID INJURY OCCUR? ---	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ---				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? ---	
22. I certify that (I) <u>this hospital</u> attended the deceased from 7-25 19 67 to 8-18 19 67 , that (I) (we) last saw the deceased alive on 8-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Z. A. McDonald				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-18-67	
23C. PHYSICIAN'S NAME (Type) Z. A. McDonald				23D. ADDRESS 4940 Eastern Ave. Balto., Md. 21224 BALTIMORE City Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-21-67				24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967				25B. NAME OF REGISTRAR Charles R. Law	
25C. FUNERAL DIRECTOR Charles R. Law				25D. ADDRESS 802 Madison Ave.					

10/10/10

10/10/10

10/10/10

10/10/10

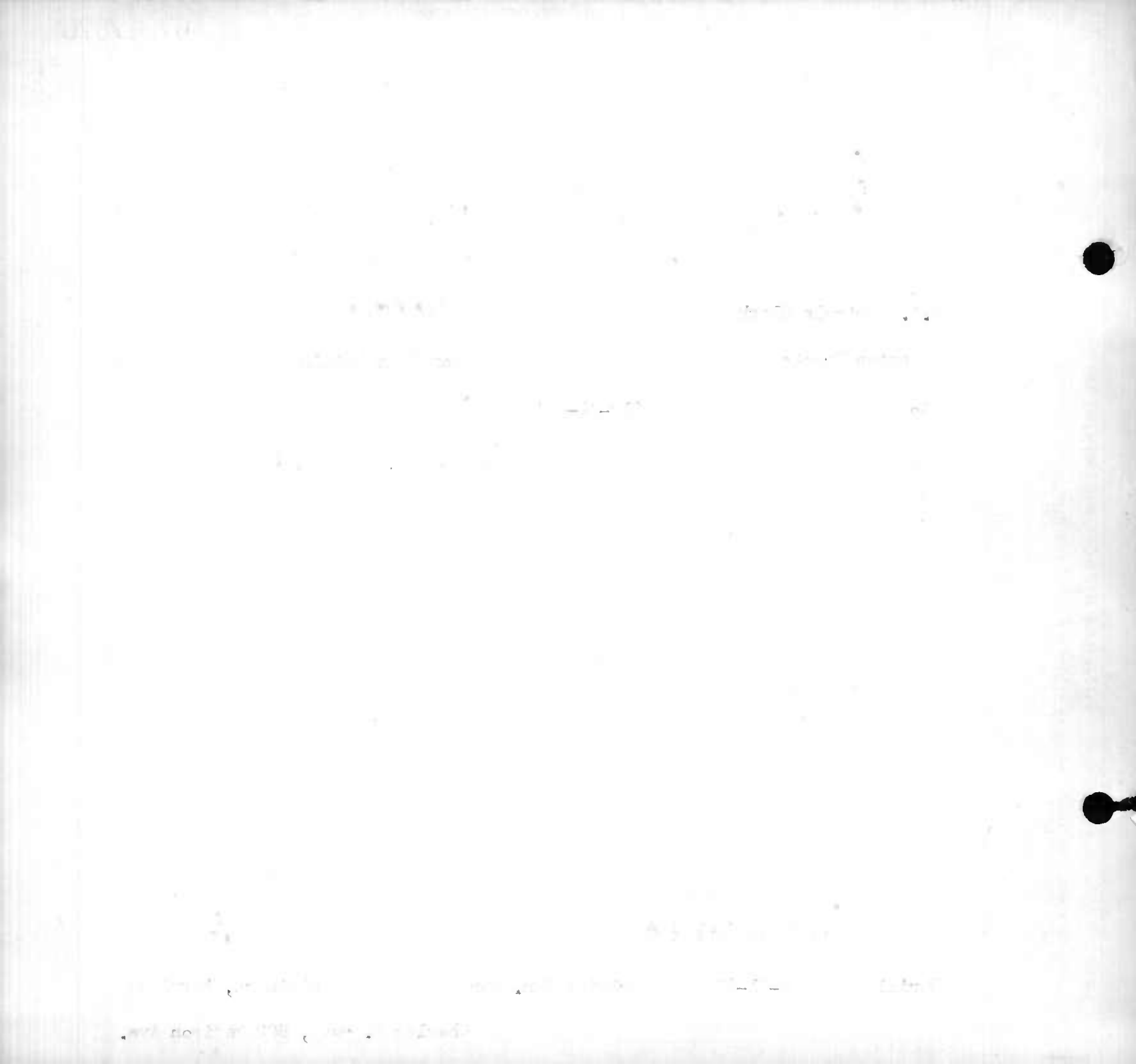
10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

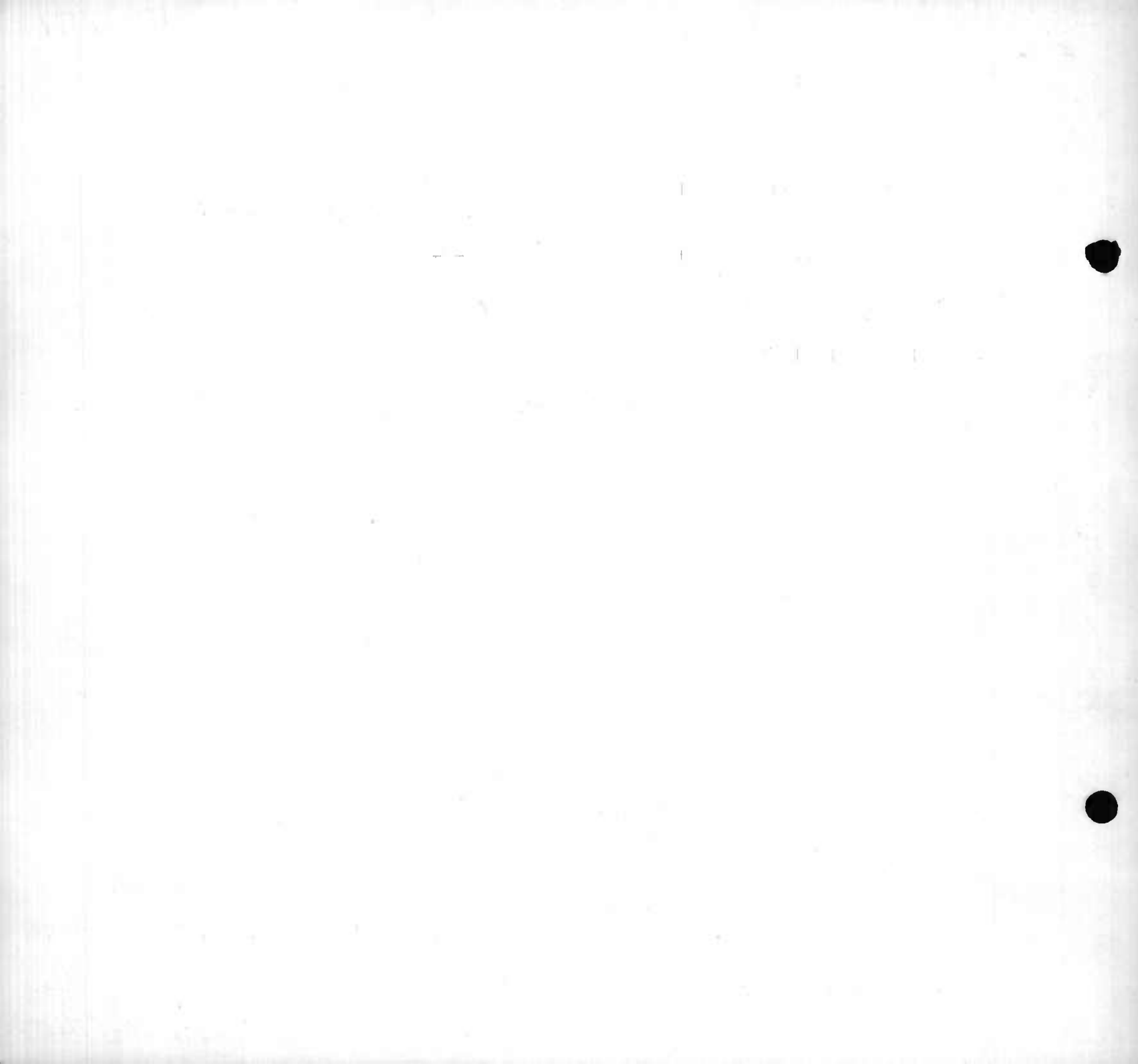
BIRTH NO. 67 7976				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7976	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				HAZEL OWENS		8-17-67 11:00 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
SINAI HOSPITAL OF BALTIMORE				MARYLAND			
BENJAMIN BLVD. AT GROENSPRING AVE.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALD, MD 21215				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1917 MORGAN AVE		# 17	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
F	NW	MARRIED	9-17-15	57	S.S. Control Clerk	MARYLAND	U.S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Benton Brooks				May Emma Watkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				219-42-6043		HOSPITAL CHART	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				3 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CVA - hemorrhage			
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8-15-1967 to 8-17-1967, that (I) (we) last saw the deceased alive on 8-17-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
YENTH RANZA						8-17-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		M.D.			
		Sinai Hospital of Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-21-67		Arbutus Mem. Park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 21 1967		Robert E. Fisher, M.D.		Charles R. Law		802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 7977	
BIRTH NO. 67 7977		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) x Mary GRIFFITH				2. DATE AND HOUR OF DEATH 8-16-67 10:40 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1227 WEST LOMBARD STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 7-3-13	9. AGE (In years lost birthday) 53	If Under 1 Yr. (If Under 24 Hrs. Months Days Hours Min.)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ISABC WILLIAMS			14. MOTHER'S MAIDEN NAME BLANCHE LONG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-22-9829		17. INFORMANT MRS. SPIELMAN 611 S. GLOVER ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 180X1			CAUSE OF DEATH (A) Hepatic failure DUE TO (B) Metastatic ca. of liver DUE TO (C) Hypernephroma of kidney			INTERVAL BETWEEN ONSET AND DEATH 1 week ? 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (M) (this hospital) attended the deceased from AUG 2 19 67 to AUG 16 19 67 , that (I) (we) last saw the deceased alive on AUG 16 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.							
23A. SIGNATURE John V. Russo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-16-67	
23C. PHYSICIAN'S NAME (Type) John V. RUSSO		23D. ADDRESS M.D. Johns Hopkins Hospital, Baltimore Md					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-19-67		24C. NAME of CEMETERY or CREMATORY GARDEN OF FAITHS		24D. LOCATION (City, town, or county) (State) BALTIMORE CO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Raymond L. Kaczorowski		ADDRESS 2525 Fleet St.	



BIRTH NO. **67 7978** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 7978**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALFRED

FILAR

2. DATE AND HOUR PRONOUNCED DEAD

8-16-67

2:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

500 So. Ann Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1-5-1908

9. AGE (in years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

FLORIST

10B. KIND OF BUSINESS OR INDUSTRY

FLORIST-SELF

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ANTHONY FILAR

14. MOTHER'S MAIDEN NAME

JOHANNA WESOLAWSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-09-9602

17. INFORMANT

ADDRESS

MRS. LILLIAN FILAR 500 S. ANN ST.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐
m. WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

CHARLES S. SPRINGATE, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-17-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-19-67

23C. NAME OF CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

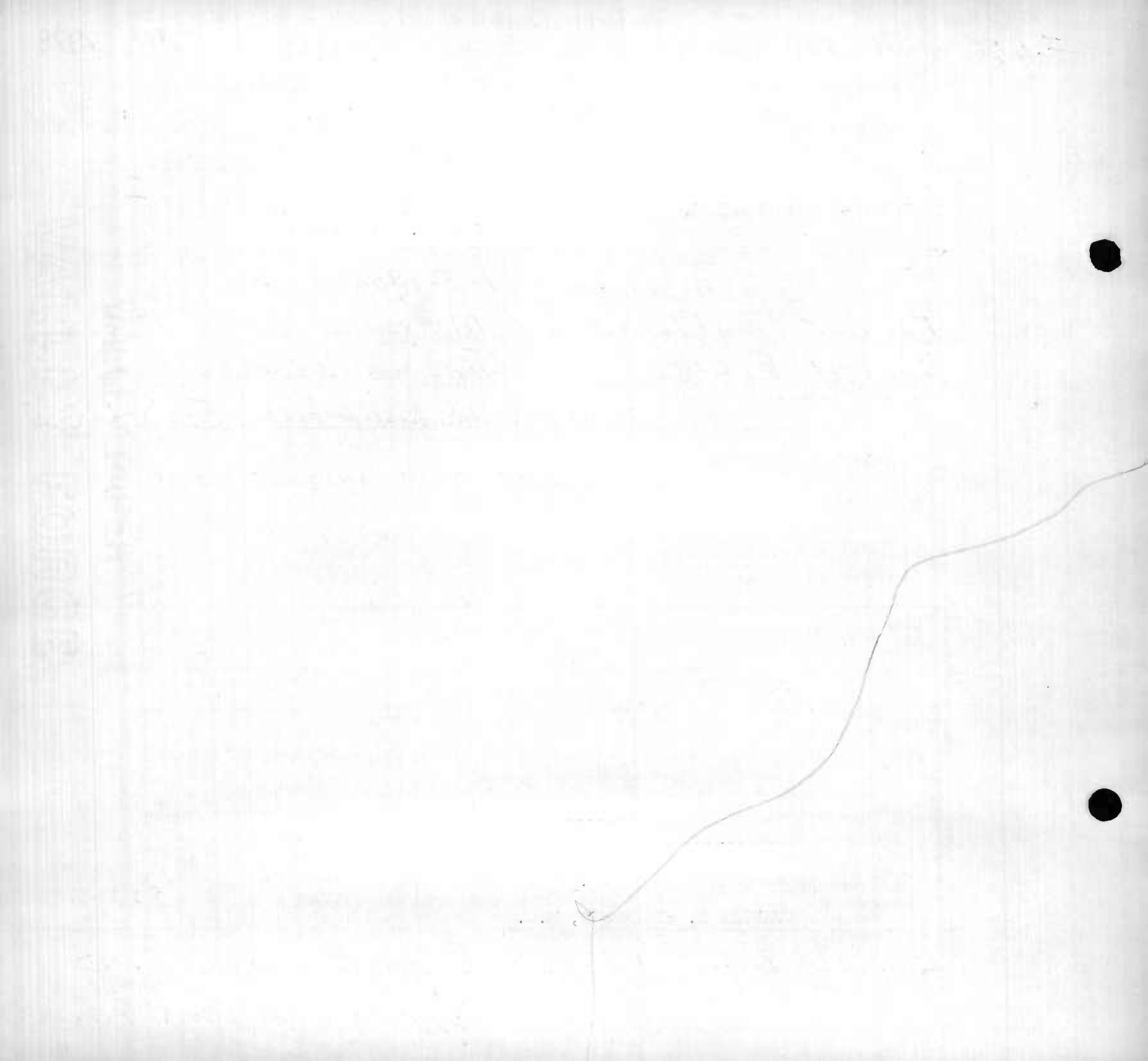
Robert E. Taylor

24C. FUNERAL DIRECTOR

Raymond L. Kaczorowski

ADDRESS

2525 FLEET ST.



1
m-324

67 7979

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7979

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEMUEL MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1967 4:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

504 E. 32th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2-10-1911

9. AGE (In years last birthday)

56

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AUTO MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

AUTOMOBILE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN MITCHELL

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Dr. Grace M. Mitchell - 504 E. 32nd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Asthma DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 16, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

8-21-67

23C. NAME OF CEMETERY or CREMATORY

GLEN HAVEN Cem.

23D. LOCATION

BALTO., Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

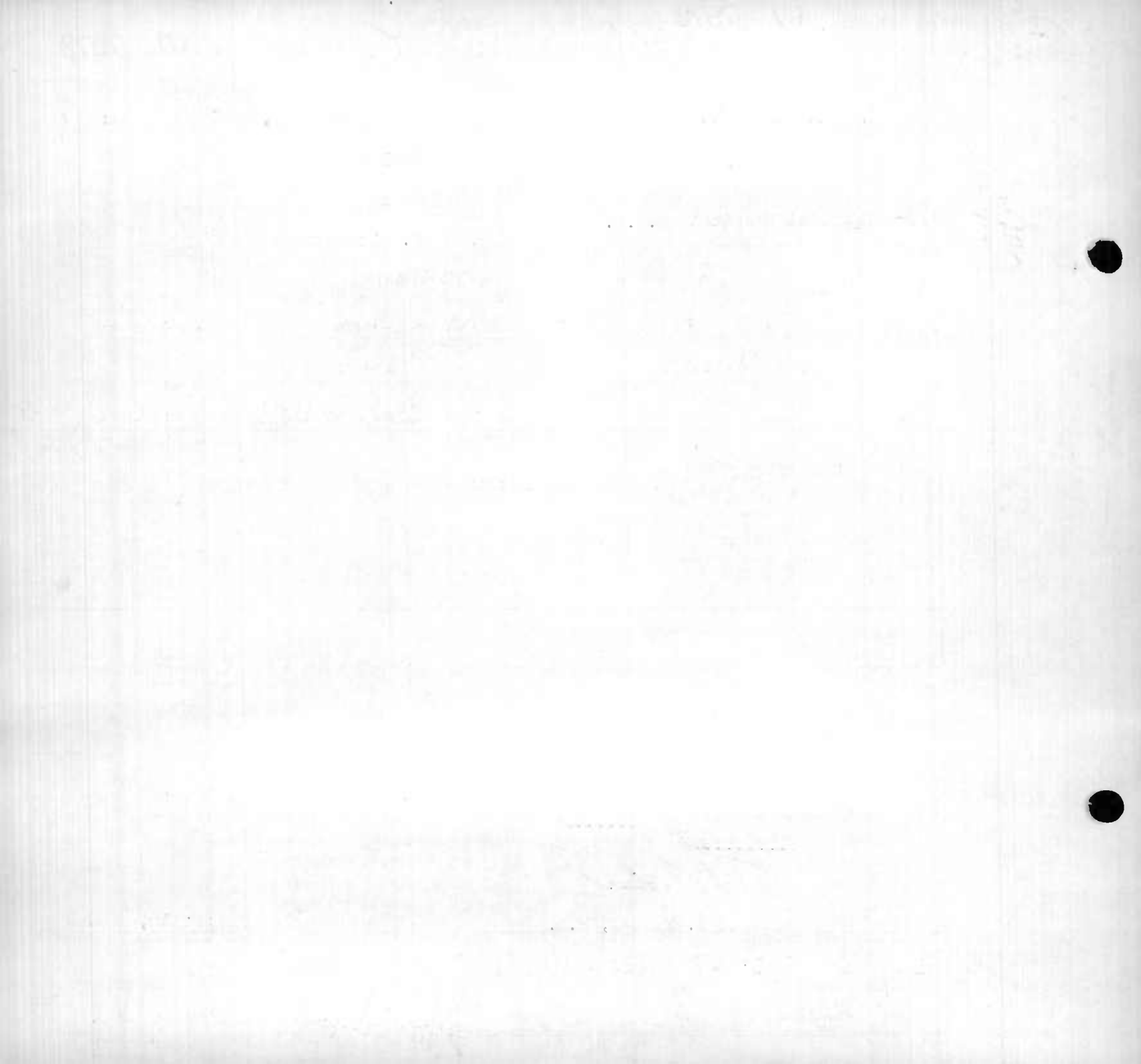
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Harley Miller - 2334 Jefferson St

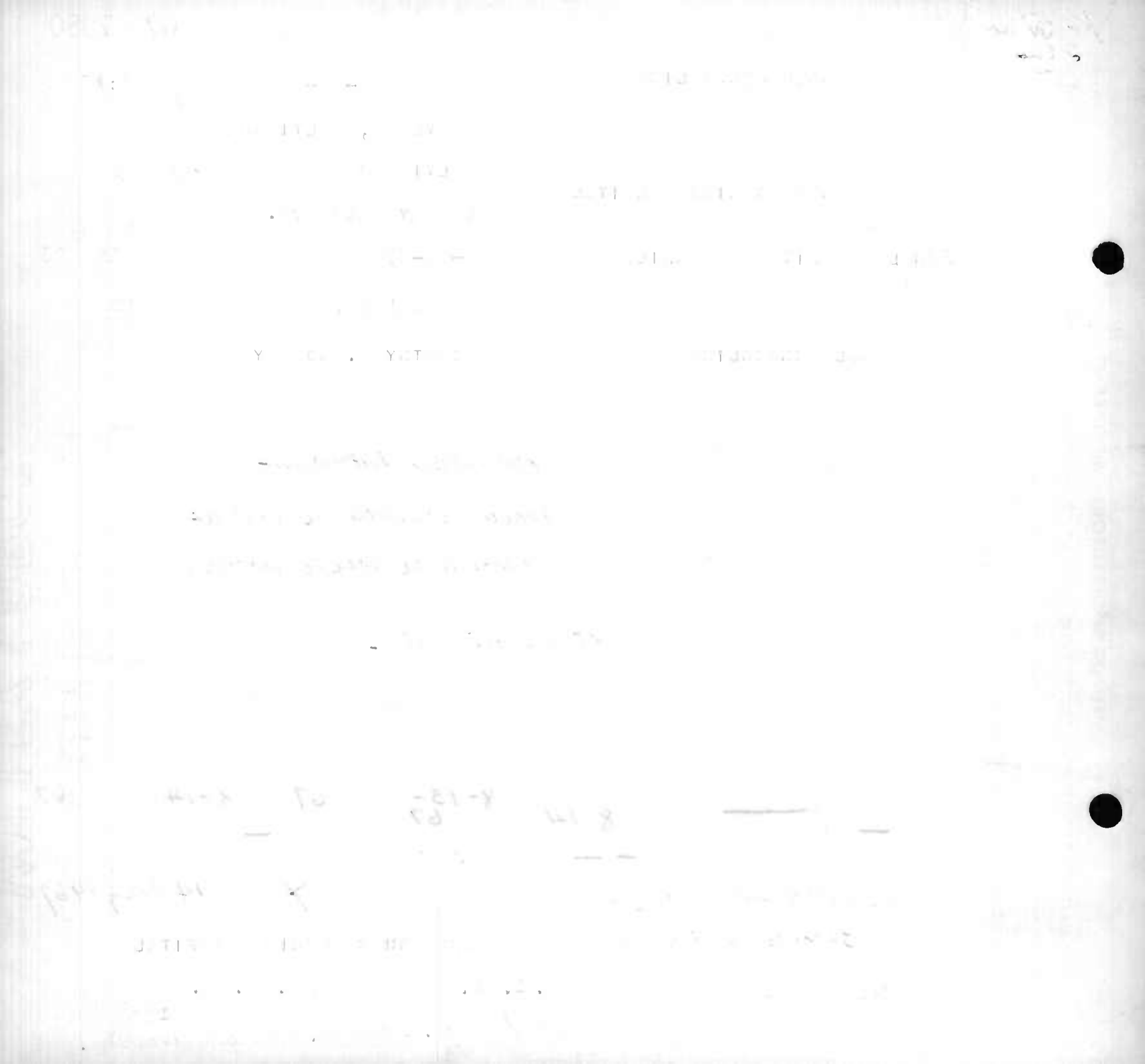
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7980	
BIRTH NO. Balto. Co., Md 67 7980		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 8-14-67 6:45 P.M.	
1. NAME OF DECEASED (Type or Print) KAREN KEMBERLING			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, BALTIMORE B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 130 LYNDALE AVE.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 8-13-67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 21 06
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PAUL KEMBERLING		14. MOTHER'S MAIDEN NAME DOROTHY P. COFFEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. 756.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. TRACH. - ESOPHAGEAL FISTULA CONGENITAL MALFORMATIONS		CAUSE OF DEATH (A) ASPIRATION PNEUMONIA DUE TO (B) TRACH. - ESOPHAGEAL FISTULA DUE TO (C) CONGENITAL MALFORMATIONS	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. IMPERFORATE ANUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8-13-1967 to 8-14-1967 , that (I) (we) last saw the deceased alive on 8-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James R. Brown		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 14 Aug 1967
23C. PHYSICIAN'S NAME (Type) JAMES R. BROWN		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-17-67	24C. NAME OF CEMETERY or CREMATORY Lakeview Mem. Pk. Cem.	24D. LOCATION (City, town, or county) (State) Balto. Co. Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Falkner	25C. FUNERAL DIRECTOR ADDRESS Wm. E. Johnson, 8521 Loch Raven Blvd.



5-350

67 7981 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7981

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RHODIE SUTTON

2. DATE AND HOUR PRONOUNCED DEAD

August 17, 1967 12:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bon Secours Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

540 South Addison Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

June 2, 1910

9. AGE (in years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lawrence Sutton

14. MOTHER'S MAIDEN NAME

Mary Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ethel Jarvis 2535 W. Balto. St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 18, 1967

23A. BURIAL CREMATION,
REMOVAL (specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

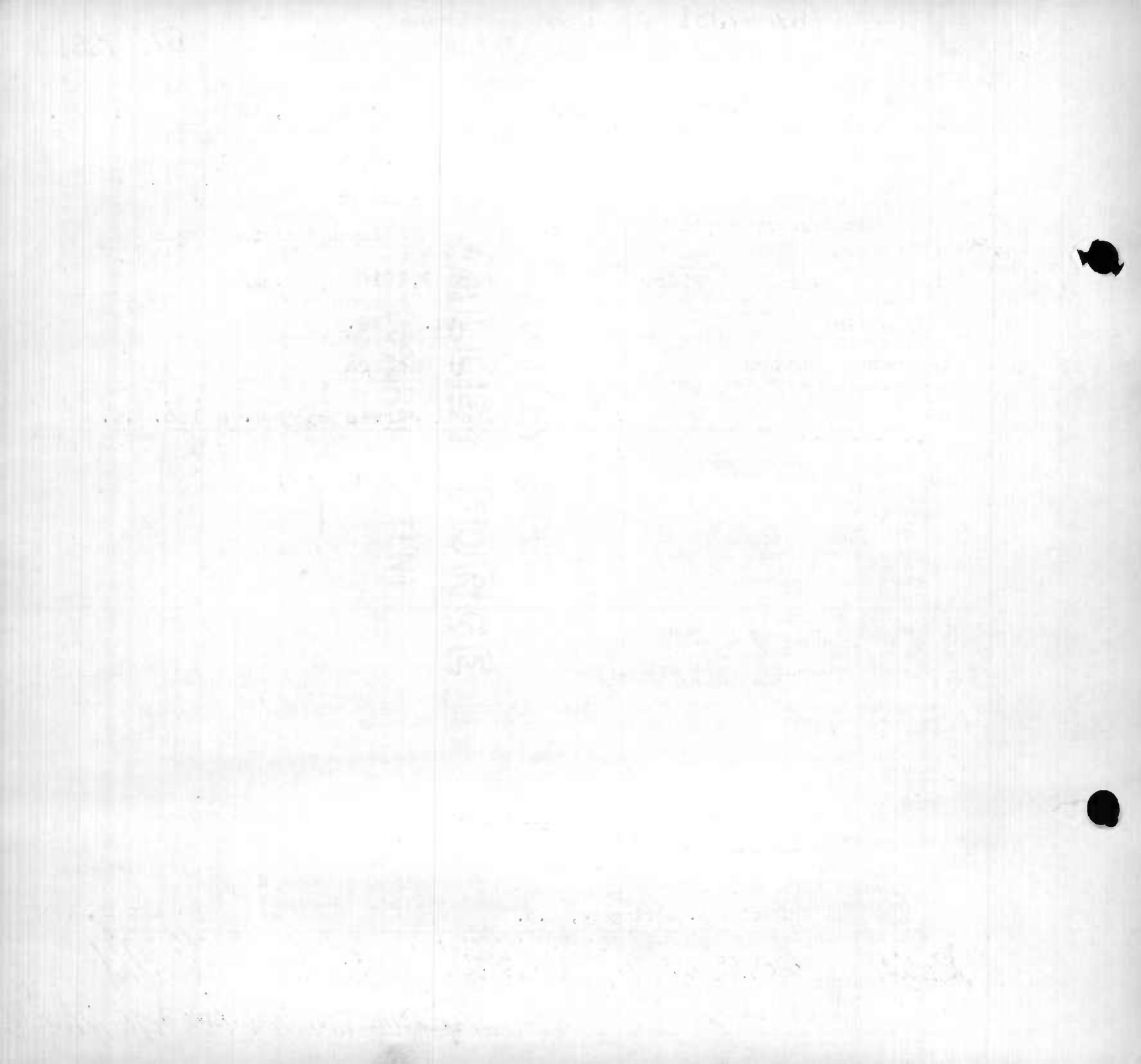
(City, town or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



1
E-120

67 7982

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67

7982

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM EPPS

2. DATE AND HOUR PRONOUNCED DEAD

August 19, 1967

9:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street
address or location)

Lutheran Hospital

8-22-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

62 S. Monastery Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married Sep.

8. DATE OF BIRTH

Oct. 2, 1915

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pantryman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Gaysburg N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Epps

14. MOTHER'S MAIDEN NAME

Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

218-03-9008

17. INFORMANT

ADDRESS

Lousie Artis 62 S. Monastery Ave.

18. 434.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute pulmonary edema

XXXX

Chronic cor pulmonale

Chronic coronary pulmonali

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 20, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 23/67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem. Balto

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schroeder

ADDRESS

Letter from M.E.'s office

8-22-67

M.H.

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROSE MOSLEY

2. DATE AND HOUR PRONOUNCED DEAD

August 18, 1967 5:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

428 Colwin Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

428 Colwin Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 29, 1912

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Richmond Va.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Eggo

14. MOTHER'S MAIDEN NAME

Ida Abernathy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Eva Thumer

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-22-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

R. E. Fisher

24C. FUNERAL DIRECTOR

Elmer G. W. W. W.

ADDRESS

1600 Brantley Ave.

Mr. William C. ...
...
...

Sept 21, 1912
Richmond Va.
The Attorney
For the ...

Kind regards
Clara ...

49-02-82
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 7984		BALTIMORE CITY HEALTH DEPT.		Registered No. 67 7984	
1. NAME OF DECEASED (Type or Print) DORSEY, Donna DORSEY, DONNA				2. DATE AND HOUR OF DEATH 8/15/67 10.20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1007 EDMONDSON AVENUE - 21223			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 1/3/35	9. AGE (In years last birthday) 32	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LINWOOD MCDANIEL				14. MOTHER'S MAIDEN NAME ALICE MOORE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospital 4940 Eastern Avenue, Balto., Md. 21224			
18. 223X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ELECTROLYTE IMBALANCE DIABETES INSIPIDUS NEPHROSIS				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/6 19 67 to 8/15 19 67 , that (I) (we) last saw the deceased alive on 8/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE Jack Brandes				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/67	
23C. PHYSICIAN'S NAME (Type) JACK BRANDES				23D. ADDRESS M.D. BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-19-67		24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR AUG 21 1967 Robert S. Thomas		25C. FUNERAL DIRECTOR Edmondson-Walker		ADDRESS 1000 Bm City Ave	



67 7985

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7985

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES

A.

BIRDSONG

(Notes)

2. DATE AND HOUR PRONOUNCED DEAD

August 14, 1967

6:40 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1507 Ashland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1507 Ashland Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Oct. 27, 1929

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Elliester Birdsong

14. MOTHER'S MAIDEN NAME

Lynette Nokes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ethel Garland 2715 E. Federal St.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/15/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-19-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Elroy O. Watson 1000 Brantly Ave

ADDRESS

Oct 21 1917
Letter to
Mr. H. H. H.
From H. H. H.

Letter to
Mr. H. H. H.

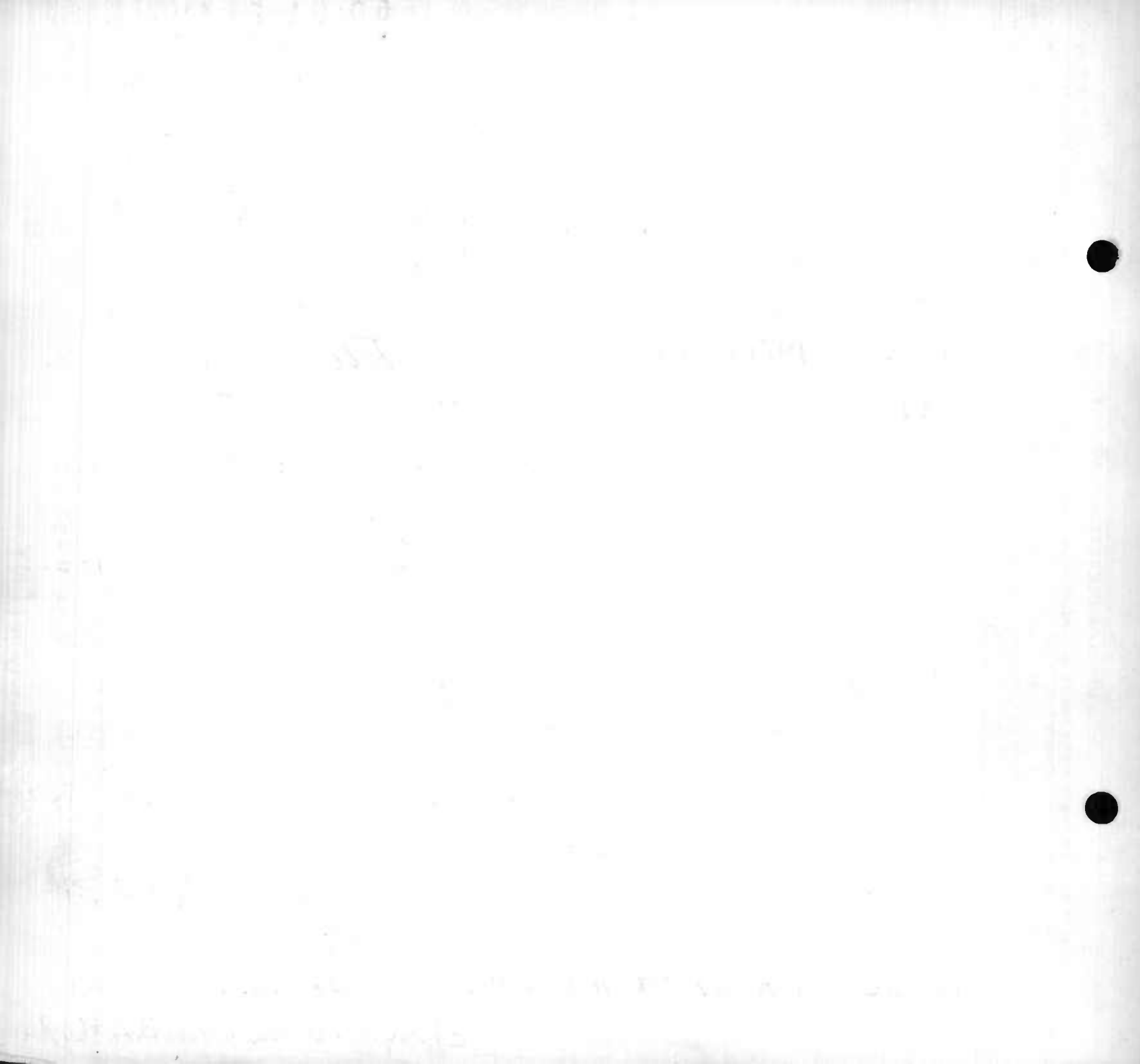
W. H. H.

Received 8-10-17
From H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

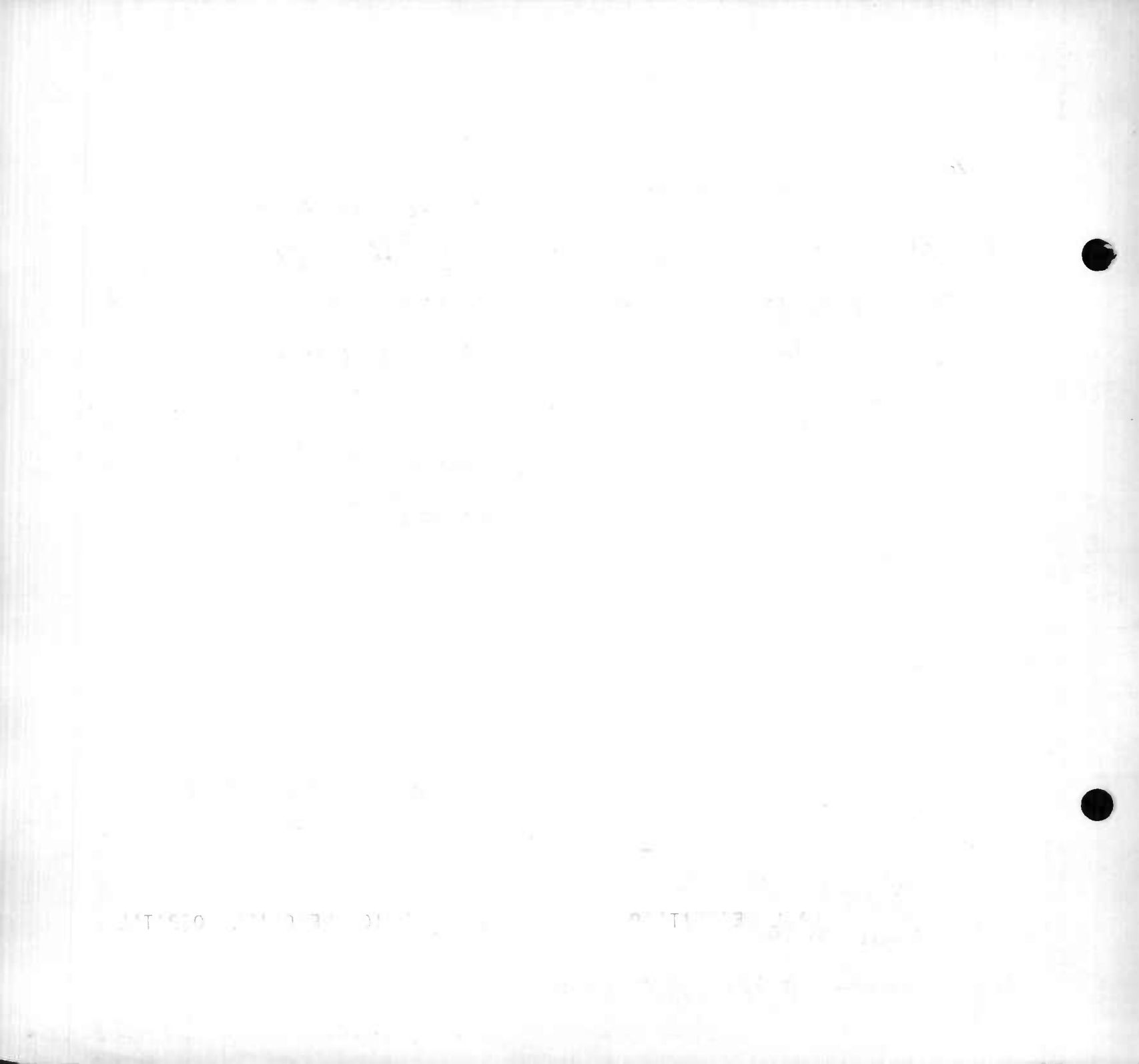
Baltimore City Health Department				67 7986		60 81 20 67 7986	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Charles Missouri				2. DATE AND HOUR OF DEATH 8/14/67 5 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				A. STATE Maryland			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1003 E. Monument St.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 9/14/14		9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Burl - Missouri				14. MOTHER'S MAIDEN NAME - Ellen Levy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT John Graber		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-8114-00211				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Gastric ulcer + gastritis DUE TO		10 days	
				(B) Chronic alcoholism + DUE TO Luer's cirrhosis		Over 10 years	
				(C) H/O pulm. TB		Over 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8/8/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI Bleeding		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 6, 1967 to Aug. 14, 1967, that (I) (we) last saw the deceased alive on Aug. 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Graber				23B. DATE SIGNED Aug. 14, 1967			
23C. PHYSICIAN'S NAME (Type) John Graber				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-1967		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR John E. Finkbeiner		25C. FUNERAL DIRECTOR Henry O. Williams		ADDRESS 1000 Brantley Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7987				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7987	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SHEPPARD, ISAAC				2. DATE AND HOUR OF DEATH 8-18 - 67 8:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		If not in hospital or institution, give street address or location		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 429-E 20th St.			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 4-28-16	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage disposal worker in Sanitation Dept.			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JUNIOR SHEPPARD				14. MOTHER'S MAIDEN NAME MAGGIE WALLACE JANE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-01-9424		17. INFORMANT ADDRESS Isaac Sheppard	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 3-8-10 I				CAUSE OF DEATH (A) Cirrhosis of the Liver DUE TO (B) Severe Epistaxis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8-16-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-16-67 to 8-18-67 , that (I) (we) last saw the deceased alive on 8-18-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Raul Desquitado				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) RAUL DESQUITADO				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE 8-22-67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cent		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Chas. Wilson		ADDRESS 1000 Brantley Ave	



1
P-613

67 7988

BALTIMORE CITY HEALTH DEPARTMENT

67 7988

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK PRIVETT

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1967

2:17 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1805 Patterson Park Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Aug. 18, 1951

9. AGE (In years
last birthday)

15

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Newport News, VA.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Privette

14. MOTHER'S MAIDEN NAME

Hazel Lilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Henry Privette

ADDRESS

Some

18. E981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of abdomen

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

8-12-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

abdominal bleeding

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Broadway and Preston Streets

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
8-11-67 11:25 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-67

23C. NAME OF CEMETERY or CREMATORY

MT. Auburn Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Ernest O. Walcott

ADDRESS

1000 Brantley Ave.

May 18, 1951

Handwritten note

Handwritten note

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BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

MATTHEWS, JR.

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1967 6:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2219 Booth St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 16, 1938

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

George Town, S. Carolina U. S. A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Matthews Sr.

14. MOTHER'S MAIDEN NAME

Viola Lydon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Viola Lydon Matthew Lydon

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive Bleeding
DUE TO Stab Wound of Chest Involving The
Right Lung.ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2219 Booth Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8/13/67

(Year) (Hour)

6:30

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. stabbed in chest with a knife.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spatz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-67

23C. NAME of CEMETERY or CREMATORY

George Town Cem.

23D. LOCATION

(City, town, or county)

(State)

Georgetown, South Carolina

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Fathman

24C. FUNERAL DIRECTOR

Fraser Funeral Home Georgetown, S.C.

ADDRESS

July 14, 1932

Mr. J. H. ...
Vice-President

Charles Matthews

10

Printed by ...

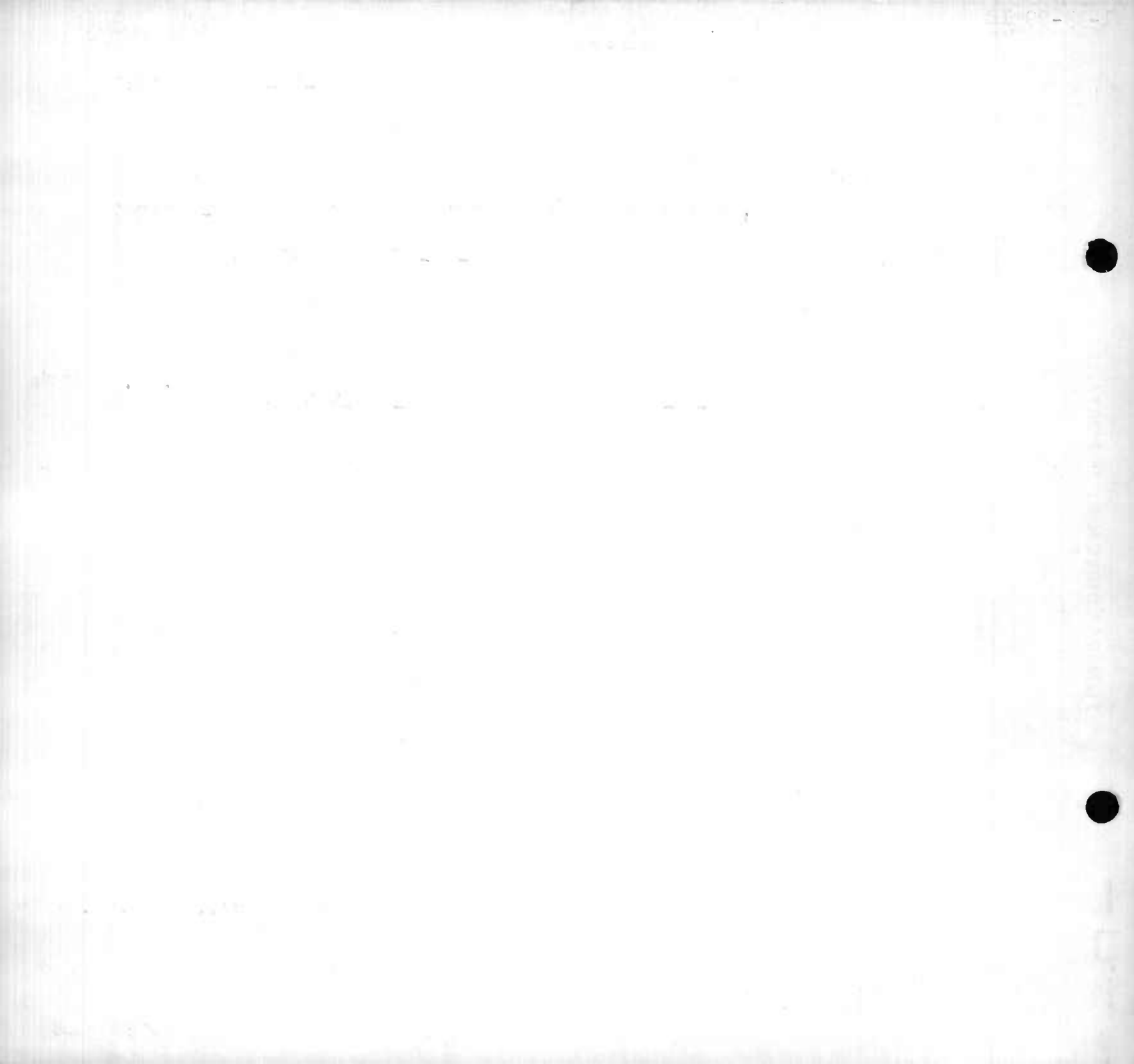
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CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

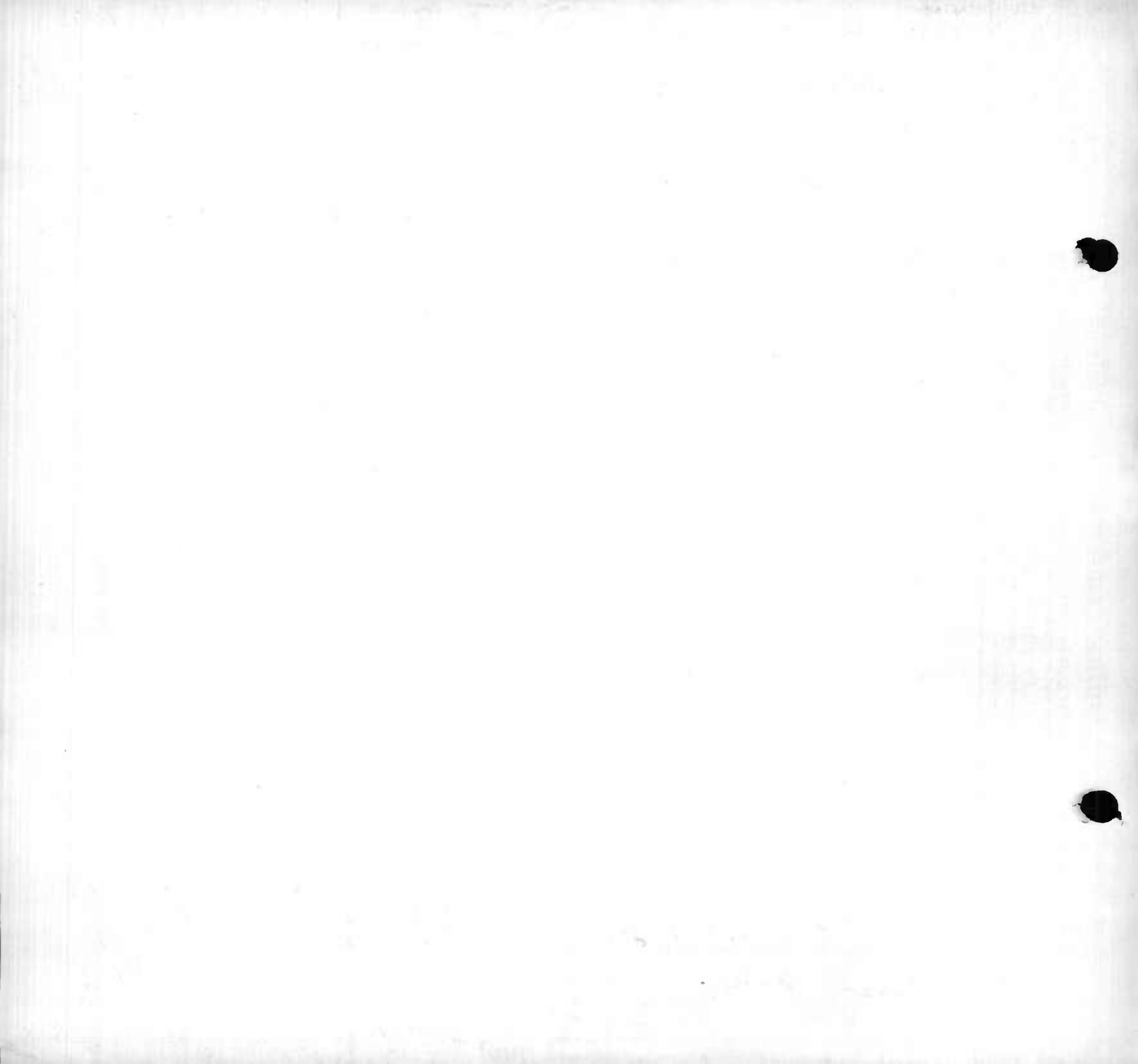
BIRTH NO. 67 7990		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7990	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLINE MAIR		2. DATE AND HOUR OF DEATH 8-18-67 10:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 1512 AISQUITH STREET - 21202		9-09	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-10-95	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DANIEL JOHNSON		14. MOTHER'S MAIDEN NAME ELIZABETH CHANDLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 220-05-8790		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BALTIMORE, MD. 21224 RECORDS-BCH-4940 EASTERN AVENUE-	
18. I 4221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE & multiple VPC's & premature beats intermittent disease CBC		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH at least 3 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Burn CVA's Multiple decubiti		1 yr. 1 yr.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/18 19 67 to 8/18 19 67 , that (I) (we) last saw the deceased alive on 8/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leonard Lippman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/18/67	
23C. PHYSICIAN'S NAME (Type) LEONARD LIPPMAN		M.D. BALT. CITY HOSPITALS		23D. ADDRESS 4940 Eastern Ave., Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-23-67		24C. NAME OF CEMETERY or CREMATORY Nottingham Cent	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE RECEIVED BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Alloy Wilson or Brantley		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7991				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7991	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) DANDRIDGE JOHN						8-10-'67 10=40 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Lutheran Hospital of Maryland				Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Baltimore				2533 W. Lanvale St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
M	C	Married	3-1-1892	74 yrs			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired					Essex Co, VA.		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Dandridge				Annie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No					James Dandridge		Same
18. 465 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) Pulmonary Embolism		4 days	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-25- 19 67 to 8-10- 19 67 , that (I) (we) last saw the deceased alive on 8-10- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Anjoshi				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-'67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI				23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton St. Baltimore 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-67		24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) Laurel Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert S. Taylor		25C. FUNERAL DIRECTOR George W. Wilson		ADDRESS 1000 Brontley Ave.	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

August 9, 1967 9:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1207 Chatham Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Mar. 21, 1917

9. AGE (In years
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

High Point N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Perry

14. MOTHER'S MAIDEN NAME

Fannie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

John Williams

ADDRESS

Same

18. 2983X

CAUSE OF DEATH

Hypertensive and arteriosclerotic
cardiovascular diseaseINTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Multiple left rib fractures with
pneumothorax, and delirium tremens

19A. DATE OF OPERATION

20A. AUTOPSY? (Yes or No)

Yes

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1207 Chatham Street

21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

8-6-67 7:00 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pushed down during altercation

22.

I certify that I held an Inquity ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-15-67

23C. NAME of CEMETERY or CREMATORY

Balto. Nat. Cem.

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 21 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Flora J. Wilson 1000 Brantley Ave.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 7993	
<div style="display: flex; justify-content: space-between;"> <div> <p>3-24-2</p> <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> </div> <div> <p>67 7993</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>67 7993</p> </div> </div>					
1. NAME OF DECEASED (Type or Print) JAMES J. McLAUGHLIN			2. DATE AND HOUR OF DEATH 8/18/67 2:00 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION _____ (If not in hospital or institution, give street address or location) 1818 Light St.			A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1818 Light St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 29, 1885	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10B. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Luke Mc Laughlin			14. MOTHER'S MAIDEN NAME Catherine Casey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT James L. Mc Laughlin	
				ADDRESS Same	
<div style="display: flex;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">MEDICAL CERTIFICATION</div> <div> <p>18. 16538 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div> <p>(A) DUE TO Carcinoma of colon</p> <p>(B) DUE TO generalized metastasis</p> <p>(C) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1965 to Aug 18 1967 , that (I) (we) last saw the deceased alive on Aug 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Lozada				23B. DATE SIGNED 8/18/67	
23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA				23D. ADDRESS 1228 S. Charles St. Baltimore, Md. 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 22 67		24C. NAME of CEMETERY or CREMATORY Holy Cross	
				24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Dr. J. J. Taylor		25C. FUNERAL DIRECTOR Mc Cully	
				ADDRESS 130 E. Fort Ave	



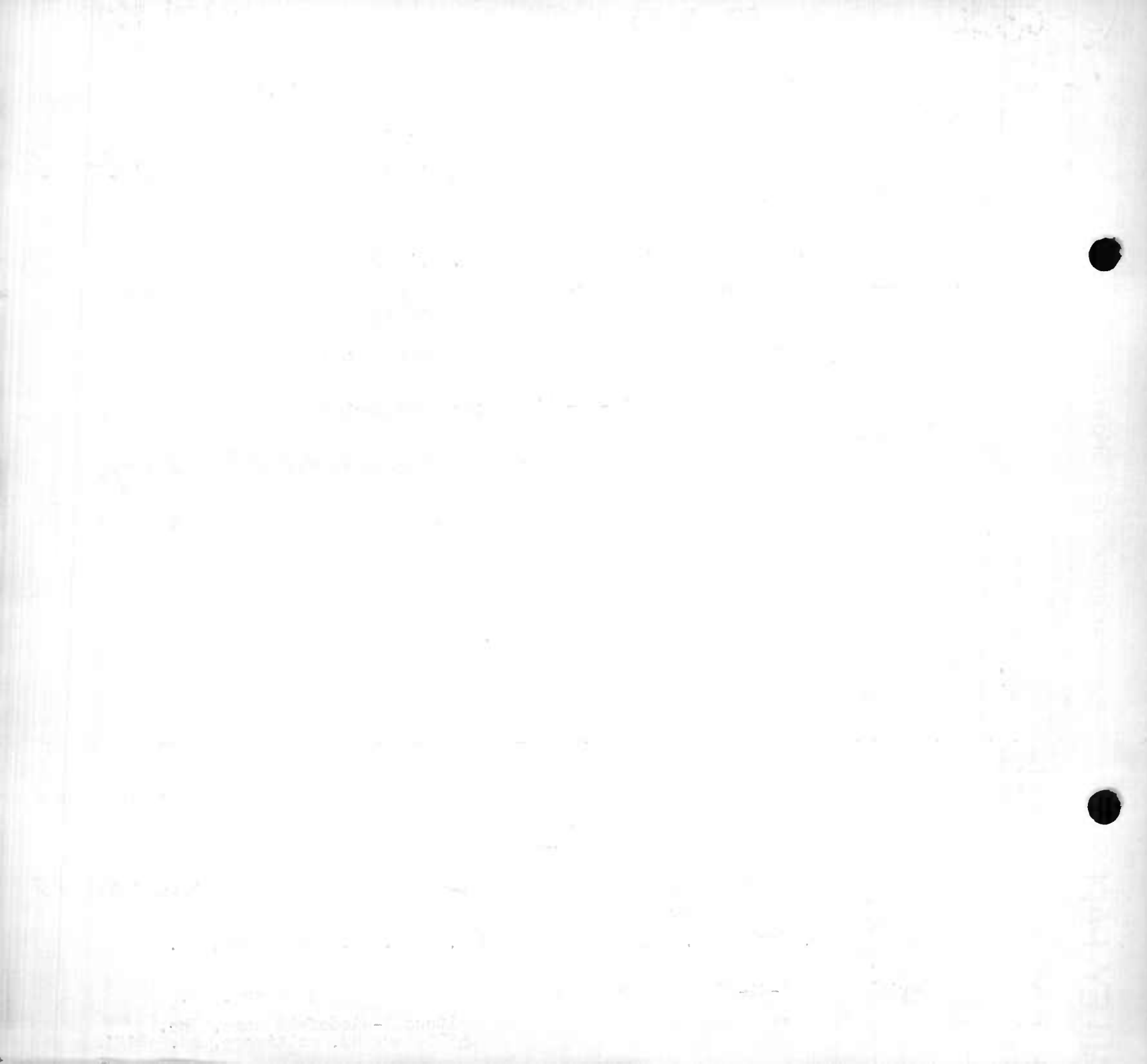
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7994				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7994	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) RUDOLPH A. DRENNAN				8/17/67		3 45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location) Mercy				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3610 Yolando Road			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Dec. 11, 1899	
						9. AGE (In years last birthday) 67	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dir. State Aviation Comm.				10B. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Gustave Drennan			
				14. MOTHER'S MAIDEN NAME Nina Reed			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW-1				16. SOCIAL SECURITY NO. 213-10-6738		17. INFORMANT Mrs. Winifred W. Drennan-	
						ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthma, etc. It means the disease or complication which caused death.) CEREBRAL INFARCT				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 wks	
ANTECEDENT CAUSES				(A) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost.				(B) DUE TO acute myocardial infarction		5 wks	
(C) urinary tract infection							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/17/67 19 57 to 8/17 19 57 , that (I) (we) last saw the deceased alive on 8/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kenneth Stern				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE, SIGNED 8/17/67	
23C. PHYSICIAN'S NAME (Type) KENNETH STERN				23D. ADDRESS Mercy Hospt.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 8/19/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Spivey		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd., 21212	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7995	
67 7995				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
KATE BORING			August 18, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3409 Greenway			A. STATE Maryland		
			B. COUNTY Baltimore		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single			8. DATE OF BIRTH Feb. 4, 1882v		
9. AGE (In years last birthday) 85			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John H. Boring			14. MOTHER'S MAIDEN NAME Amelia Shier		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-48-2117		
17. INFORMANT Miss Ruth Boring			ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Central Vascular Accident			INTERVAL BETWEEN ONSET AND DEATH 5 days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ASCVD Several years?		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 13, 1967 to August 18, 1967 , that (I) (we) last saw the deceased alive on August 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Newland E. Day		23B. DATE SIGNED August 18, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. Newland E. Day		23D. ADDRESS 4 E. 33rd. St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-67		24C. NAME of CEMETERY or CREMATORY Green Mount	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.			
25D. ADDRESS 6500 York Rd. Baltimore, Md.		25E. ADDRESS 21212			



67 7996

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 7996

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)~~MARION~~

BESSIE LEONA

TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1967

7:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1608 W. Baltimore St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1608 W. Baltimore St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

JAN. 13, 1928

9. AGE (In years
last birthday)

39 40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wilson Taylor

14. MOTHER'S MAIDEN NAME

Virgie Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

ADDRESS

Mr. Hobert Taylor-3031 Matthews St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Alteration of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/13/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/18/67

23C. NAME of CEMETERY or CREMATORY

Mt. Olivet

23D. LOCATION

(City, town, or county)

(State)

Balto

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 21 1967

Robert E. Farber, M.D.

Mitchell-Wiedefeld Home, Inc.
6500 York Road, 21212

XXXX

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 7997	
BIRTH NO. 64-23009 67 7997				Registered No.	
M.E. CASE NO.				1. NAME OF DECEASED	
(Type or Print) <u>Lee Beall</u>				2. DATE AND HOUR OF DEATH <u>8/19/67</u> <u>12 45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>				D. STREET ADDRESS (If rural, give location) <u>1402 Clarkson St. 21230</u>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>8/26/64</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		9. AGE (In years last birthday) <u>2 1/2</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Beall</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Finger</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. chart</u>				ADDRESS	
18. <u>193.41</u> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Neuroblastoma</u>				(A) DUE TO <u>5 mos.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				(B) DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 8</u> 19 <u>67</u> to <u>Aug 19</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 19</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Franklin L. Johnson</u>				23B. DATE SIGNED <u>Aug 19, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Franklin L. Johnson</u>				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-22-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION <u>Glen Burnie, AA.</u>		24E. CITY, TOWN, OR COUNTY <u>MD.</u>		24F. STATE <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>McCollig - 130 E. Fort Ave. Balto, MD 21200</u>	

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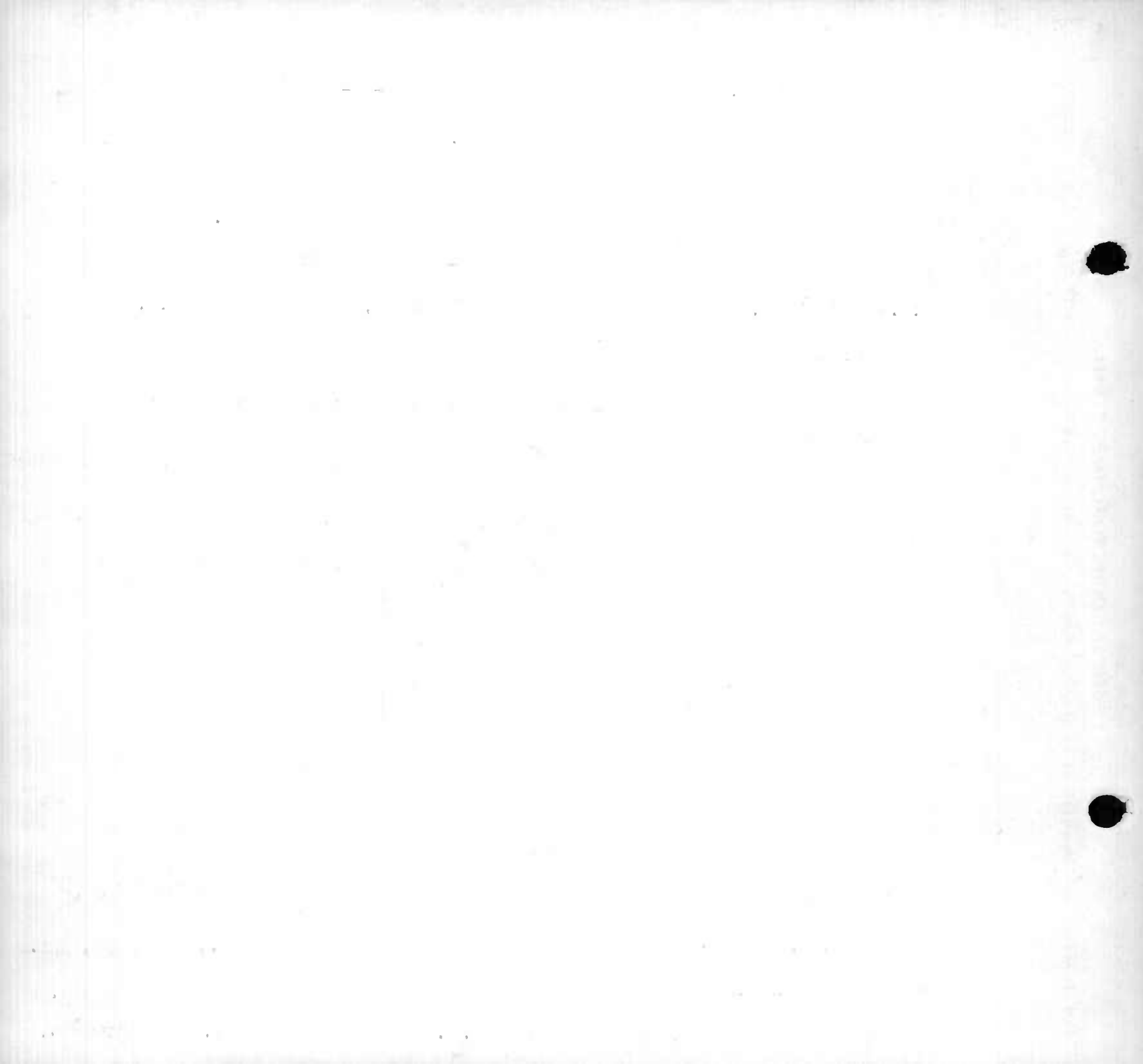
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

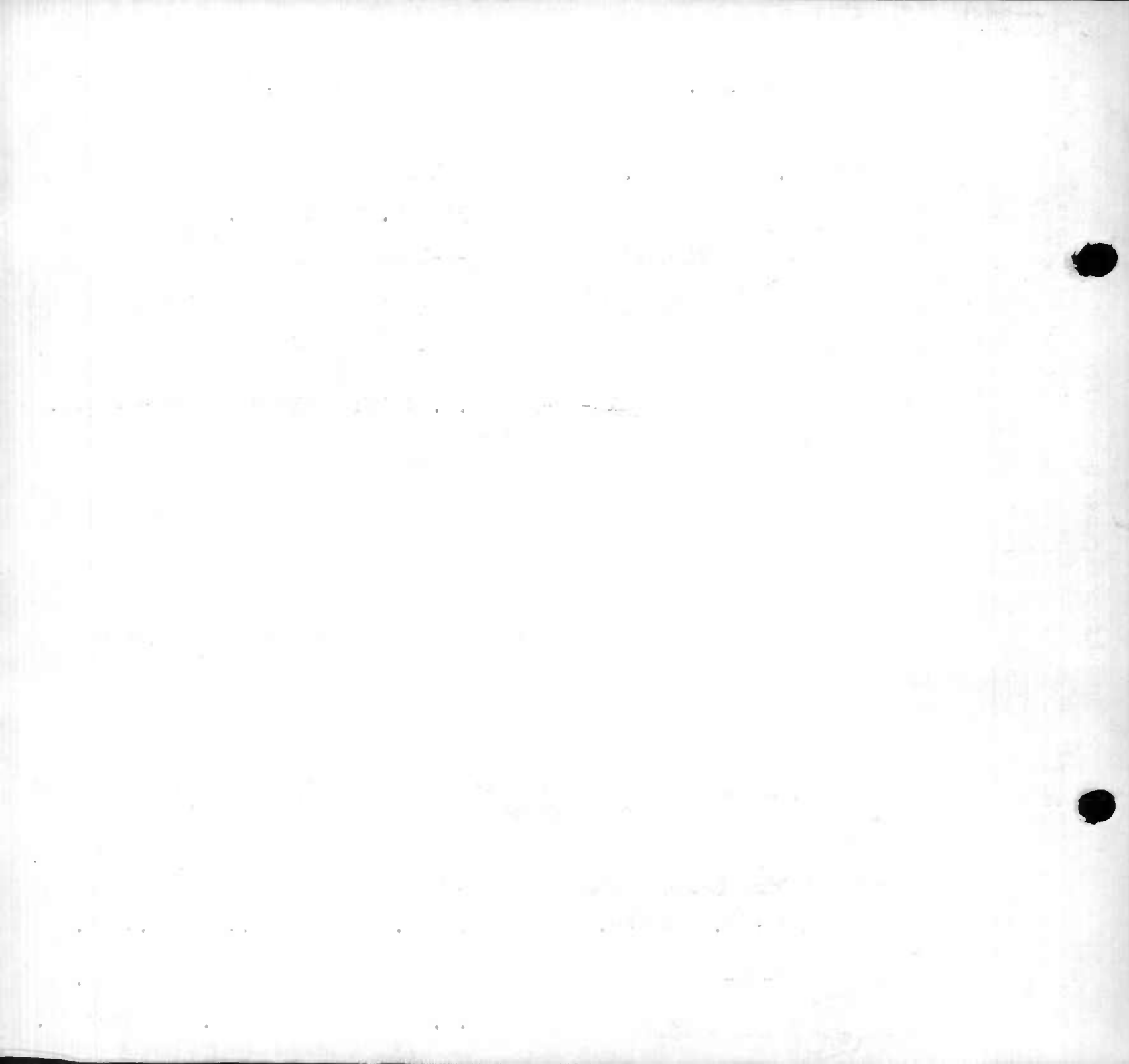
BIRTH NO. 67 7998				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 7998	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ETHEL G. ARMSTRONG				2. DATE AND HOUR OF DEATH 8-19-67 7:10 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-12 D. STREET ADDRESS (If rural, give location) 5411 Willowmere Way Balt. 21212			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-2-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.-Ass't Dir.		10B. KIND OF BUSINESS OR INDUSTRY Red Cross		11. BIRTHPLACE (State or foreign country) Charlotte, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Garside				14. MOTHER'S MAIDEN NAME Mary Mallon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-9188		17. INFORMANT ADDRESS Records Jenkins Memorial Hospital			
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Cerebrovascular accident 1966 & recent DUE TO (B) Generalized arteriosclerosis years DUE TO (C) Chronic degenerative heart disease years INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 21 19 66 to AUG 19 19 67 , that (I) (we) last saw the deceased alive on AUG 18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. M. Rodriguez				23B. DATE SIGNED 8-19-67		23C. ADDRESS 1424 Sulphur Spring Rd., Arbutus, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-67		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 7999	
BIRTH NO. 67 7999		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Roscoe E. Grove		August 18, 1967 3:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
3900 N. Charles St.			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			3900 N. Charles St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	W	Widowed	3-6-1884	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales		Auto Club		Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Dewitt Grove			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			215-05-3353		R.M. Smith Calvert & Redwood Sts.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
442X I			Ventricular		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Interval BETWEEN ONSET AND DEATH		
Cerebral Hemorrhage			1 year		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1, 1963 to Aug 18, 1967, that (I) (we) lost saw the deceased alive on August 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles E. Carr Jr.				8/19/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Charles E. Carr Jr.				3900 N. Charles St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-21-67		Woodlawn	
				Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 21 1967		H. W. Jenkins		H. W. Jenkins & Sons Co. 4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2000				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2000	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Linton B. Siemon		August 18, 1967 4:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Baltimore	
1108 E. Belvedere Ave.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		27-38	
D. STREET ADDRESS (If rural, give location) 1108 E. Belvedere Ave.							
5. SEX M	6. RACE F	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-27-1901	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Siemon				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-28-4382A		17. INFORMANT Mrs. Mabel D. Siemon		ADDRESS Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ARTERIOSCLEROTIC - DUE TO (C) CARDIO-VASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 40 MIN 16 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from APRIL 1967 to AUGUST 18 1967, that (I) (we) last saw the deceased alive on AUG. 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Lloyd E. Saylor				M.D. <input type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED AUG. 20, 1967	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor				23D. ADDRESS 3902 Greenmount Ave., Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Balt. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1967		25B. NAME OF REGISTRAR H. W. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Rd.	

